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PUBLIC/PRIVATE PARTNERSHIPS: INNOVATIVE APPROACHES TO LONG-TERM CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

EXAMINING INNOVATIVE APPROACHES TO LONG-TERM CARE

JANUARY 17, 1989
INDIANAPOLIS, IN

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CONTENTS

STATEMENTS

JANUARY 17, 1990

Page

Lytle, L. Ben, president and CEO, The Associate Group, Mark Meiners, Ph.D., director, Robert Wood Johnson Foundation Study on Long-Term Care, Center on Aging, University of Maryland; and Hon. Douglas Hunt, Indiana State Senator, South Bend, IN 4
  Prepared statements of:
    Mr. Lytle 7
    Mr. Meiners 16
    Senator Hunt 26

Sullivan, Mike, director, Indiana Association of Home Health Agencies; Hon. John thomas, Indiana State Representative, Brazil, IN; Eleanor Kinney, associate professor of law and director, Center for Law and Health, Indiana University School of Law, Indianapolis, IN; Jeff Richardson, acting commissioner, Department of Human Services, State of Indiana; and Scott R. Severns, attorney, Severns and Lewis, policy analyst, United Senior Action of Indiana 42
  Prepared statements of:
    Mr. Sullivan 46
    Mr. Thomas 54
    Ms. Kinney 64
    Mr. Severns 86

Cowgill, Carol, project director, Indiana Long-Term Care Insurance Program, on behalf Pamela Carter, the Governor's executive assistant for Health and Human Services, Indianapolis, IN, prepared statement 114

The Health Insurance Association of America, prepared statement 123

Etienne, Duane, president, Central Indiana Council on Aging, Inc., Indianapolis, IN, prepared statement 130

PUBLIC/PRIVATE PARTNERSHIPS: INNOVATIVE APPROACHES TO LONG-TERM CARE

WEDNESDAY, JANUARY 17, 1990

U.S. SENATE,
SUBCOMMITTEE ON AGING OF THE
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Indianapolis, IN.

The committee met, pursuant to notice, at 9:00 a.m., in the Marion County Central Library, 40 East Clair Street, Indianapolis, IN, Senator Dan Coats presiding.

Present: Senator Coats.

OPENING STATEMENT OF SENATOR COATS

Senator COATS. I want to personally thank those in attendance this morning for your interest in what I think is a very important subject and one in which you all play a very critical role in policy discussions not only in the U.S. Congress but also in State legislatures across the Nation in the decade of the 1990's. I want to thank also our witnesses who have made their time and talents available to us this morning to come and present their thoughts and views on issues relative to long-term care and give us suggestions and advice and guidance as to policy decisions that we are going to need to make in the years ahead.

In one sense I guess the fact that the growing need for long-term care services reflects some good news, and that good news is that the people are living longer; they are healthier. And of course we are all happy for that fact. On the other hand, it does present the challenges for the health care system, health care delivery system, and indicates the need for some innovative solutions in providing needed services to our elderly.

We know that currently a million and a half, approximately a million and a half elderly persons are residents of nursing homes. By the time an individual reaches the age of 65, that person is estimated to have more than a 43 percent risk of entering a nursing home at some time during his or her life. And for every elderly person residing in a nursing home, we know there are at least twice as many elderly persons living in the community that require some type of assistance to maintain residence in their home. Because people over 85 are the fastest growing age group in America, estimates for the future show that nursing home population might reach as high as 4.4 million by the year 2040 and that disabled elderly population living in the community might include up to 14.5 million persons by that same time. And so with nursing home care costing today an average of 20,000 TO $25,000 PER YEAR PER RESIDENT, WE CAN ONLY IMAGINE WHAT KIND OF COSTS WE WILL BE FACED WITH IN THE FUTURE FOR INSTITUTIONAL CARE.

So I think the question that comes to us this morning: How are we to approach these types of demands and insure that the elderly and disabled will receive adequate and appropriate care, and what role does private insurance, governmental and individual expenditures play in financing and achieving these goals?

In 1987, the National Task Force on Long-term Health Care Policies recommended to the Congress that there needs to be a greater use of private long-term care insurance. According to the task force, this type of insurance offers, and I quote, "The most cost effective collective approach to meeting financial risks that often devastate individuals." Task force also concluded that suitable coverage could not be obtained without also addressing the need for public awareness, consumer protection, market development and tax incentive.

Our first panel of today's hearing will focus on many of these concerns and share how such a public/private partnership program as that advocated by the Robert Wood Johnson Foundation to promote long-term care insurance might work. And I am pleased that the legislation that I have sponsored in the U.S. Senate as well as legislation sponsored by two of our panelists this morning has given an assist to the process of embarking upon this demonstration program.

I look forward today to learning more about how various home care options can provide needed services for our elderly, and so our second panel will comment on approaches and options—with special attention being given to the State's Choice Program—community and whole options to institutionalized care for the elderly and disabled.

It is because of Indiana's initiatives in the area of looking at long-term care that I went to Senator Kennedy and Senator Matsunaga and asked permission to hold this official hearing in Indianapolis to explore the programs and options that the State of Indiana is looking at, to bring back information relevant to this question and to utilize this information in discussion with the committee options that we ought to be looking at for national policies affecting long-term health care; and I want to thank Senator Kennedy and Senator Matsunaga for their permission to hold this hearing today in Indianapolis.

The testimony that will be given will become an official part of the Senate Committee on Aging which is a Subcommittee on Aging of the Labor and Human Resources Committee. One of the dilemmas that we faced was accommodating all those who have had background and experience in this area. We wish we had time for everyone to testify. I want to assure those in attendance here, though, that even though you may not be a formal witness, we will be happy to receive any written testimony or other materials that you wish to have entered in the official record, and I will insure that that testimony is entered in the record. So for those of you who are not testifying or for those of you who may be summarizing your remarks, which I hope you will do, during your testimony but have a longer testimony to include in the record, we will make sure that every word of your written testimony is entered into and becomes an official part of the record.

Thank you again for your attendance this morning. We look forward to the testimony of our witnesses. Just prior to that, we are going to have a very brief video presentation entitled "Can't Afford to Grow Old." We will use that as a basis to start our program this morning and then call our witnesses.

I'd like to give special recognition to the two people you see and will see scurrying around here this morning. They are doing a lot more than just pushing buttons. They are responsible for these issues on my legislative staff. Both Dane Starbuck from my Washington staff and Michelle Hopkins from my Indiana staff have a great deal of experience and background and spend a lot of time on the issue of health care, and I appreciate all their hard work in not only putting this program together but throughout the year in addressing the needs of our elderly on health care issues and other long-term care issues. Without further ado, let me turn it over to Dane and hit the lights and start the video.

[Short film clip was shown.]

Senator COATS. We just wanted to show you a portion of that as a way of raising the issues. Clearly there is a place for institutional care. There are many fine institutions that take very good care of people, but clearly there ought to be a range of options available. As someone that has personally experienced a lot of what we just saw in the last few years with my father, 7 years of home care and then finally the same difficult decision for institutional care, that hits home to me, and I am sure it hits home to many people here in the audience. With that, why don't we begin to explore options that are available for care, and we look forward to our presentations from a number of distinguished people this morning.

Our first panel consists of four individuals who will give us an overview and then explore a specific program that the State is embarking on. Our first presenter will be L. Ben Lytle, who is president and CEO of The Associate Group. Ben will give us an overview of health care in the 1990's with a special emphasis on long-term care. And I would also like to call up to the witness table Dr. Mark Meiners, director of Robert Wood Johnson Foundation Program to Promote Long-term Care Insurance for the Elderly; State Senator Doug Hunt from South Bend who has been instrumental in working in the Indiana Senate to promote and make sure that the State involvement in the Robert Wood Johnson Foundation program is efficient and effective and able to move forward with that program, as well as a number of other initiatives that he has been involved in in the Senate; and then Representative Jeffrey Espich from Bluffton, IN, who has done similar work in the House. I do not see Jeff, but I assume he will be joining us shortly. So why don't we call forward Ben, Mark, and Doug, and then we will have Jeff join us when he gets here.

Ben, we will have you lead off with your presentation. And I want to thank all the witnesses for their willingness to participate this morning.

STATEMENT OF L. BEN LYTLE, PRESIDENT AND CEO, THE ASSOCIATE GROUP; MARK MEINERS, PH.D., DIRECTOR, ROBERT WOOD JOHNSON FOUNDATION STUDY ON LONG-TERM CARE, CENTER ON AGING, UNIVERSITY OF MARYLAND; AND HON. DOUGLAS HUNT, INDIANA STATE SENATOR, SOUTH BEND, IN

Mr. **Lytle**. Thank you. Thank you, Senator Coats. You have certainly assembled an impressive group of people here today, and I feel very privileged to be part of the program. Senator Doug Hunt and Jeff Espich and Carol Cowgill and Mark Meiners and certainly you, Senator, played a very key role in implementing an innovative approach to long-term care embodied in S. 107, and that is the type of public/private initiative that I think we are going to need if we are going to solve the health care and long-term care challenges that we face in the future. Indiana has been a leader in public/private approaches to social problems, and we are also a leader among the States in recognizing that reform is needed in our health care system. And as you know, I have been asked to chair a commission on State health policy that was created——

Senator **Coats**. Excuse me a second, Ben. I guess some people are having trouble hearing you in the back. If you could pull that toward you, that would help out.

Mr. **Lytle**. Any better? As you know, I have been asked to chair a commission on State health policy created by Governor Bayh in the General Assembly, and this commission may provide a vehicle to implement meaningful reform and further serve as a pilot for elements of national reform.

My company, The Associated Group, is the 19th largest health insurance company in the United States, and we have a significant volume of business across the United States, including business in 22 of the larger States like Texas, California, and Florida. But I can tell you from our experience that while Indiana is only 2 percent of the Nation's population, it is a microcosm of all the health care issues we face in the United States. And you do not have to travel 1,000 miles to find all of the problems, or all the challenges. You can find them right here in Indiana. And as such, I think it may serve as a good ground, given our history of public/private partnership, to resolve many of the problems.

With that background, I thought it might be useful for me to outline what I believe our most pressing challenges are for the 1990's and offer a perspective on how these problems might be addressed. My perspective, as you might well imagine, is that long-term care can most effectively be addressed as part of an overall system of health care reform, and because it is going to make available the resources we need for long-term care.

With that, let me outline what I think some of our major challenges are as we face the 1990's. First of all, we have a health care system that provides superb quality of care but it costs too much and it is poorly distributed, so that some people do not get the care they need and others get care they probably do not need. Now, what do I mean by this? Well, I mean we have more than enough doctors and hospitals to meet our needs, but they are very often in the wrong place. The best parts of big cities and large communities have more, have excess capacity, while rural areas and inner cities go wanting. It means we have general hospital beds which we do not need and not enough long-term care beds and home care which we do need. It means that we have a long-term care system that serves the poor but leaves the middle class seriously at risk. It means that 15 to 25 percent of all medical treatment that is rendered is medically unnecessary, rendered because of inadequately educated providers and patients and because it gets paid for whether it was medically necessary or not, while 30 million of our people go without adequate health insurance coverage.

Second major challenge I think we face is that we have not yet as a people squarely faced challenges of the future in health care and made the kind of mature choices that we have to make about balancing the amount and quality of health care we wish and how we are going to pay for it and how much we are willing to pay and about the balance of responsibility between individuals and government.

People, some people, are looking for quick, painless solutions to our problems. Some people want to quickly adopt the systems of other countries without understanding the price those countries pay in rationing of care and the inconvenience to patients and without recognizing the inherent differences between societies of those countries and their social problems and our societies. We have to recognize that the system has got to be for the patients, not for the providers and not for the insurance companies and not for the payers, but for the patients, and be built for the patients.

Everyone wants to blame everyone else for the problems and challenges we have today and shift the responsibility to someone else so that they do not have to change. Everyone involved in the health care system is responsible for the problems today. We all have to share that responsibility. Providers render medically unnecessary care to increase incomes, avoid litigation or because they lack adequate training. They raise charges based on their need rather than on increased costs or competition. Employers and other payers, despite all the talk about high costs, have continued to broaden coverage for employees without adequate caution, and the result has been a 13-percent annual increase in employee health care expenditures over the last decade. Insurers and administrators have ventured deep into medical management, all without adequate credentials and frequently complicating the situation rather than improving it. Insurers have entered and abandoned health insurance business at will, aggravating the situation of costs. The public has high expectations of health care systems without complete acceptance of the cost, and most people learn to meet the expectations. We tend to want to avoid responsibility for the difficult moral choices we make, and we tend to pursue high risk behavior in our life without accepting the cost consequences to our health.

And finally, government has tinkered with the health care system rather than coming to grips with the economic and moral reality. It has yielded to special interest, mandated benefits and implemented half-hearted and ill-directed regulation rather than serving broad consumer interests. And an exception to that, I think, was S. 107, which did try to deal with the reality.

What then can we do to reform the health care system to get it to do what we want it to do and provide the type of long-term care that we should provide and need to provide for our elderly? First of all, we have to restore economic discipline in the system; supply and demand have to be allowed to work. People have to be economically accountable for the decisions they make.

Second, we have to redistribute health care resources away from where we do not need it and to where we need it, away from general hospital in-patient beds to long-term care and home care, away from excess capacity in one geographic area to another.

Third, we have to concentrate on managing the concentrations in the health care system. A very small percentage of our population consumes the bulk of health care resources. Three to 5 percent of the population consumed 50 percent of all the health care resources in the United States. Ten percent consumed 75 percent. A handful of diagnoses out of the thousands of possible diseases likewise consumes the bulk of the resources.

Fourth, we have to change attitudes. We have to step up to this challenge the same way our society stepped up to others. And finally, we have got to provide for every person in this country a minimal level of care necessary to allow them to function and have a meaningful life. But I think if we do the things above, that is certainly possible.

How do we put these things into action and can they be put into action? I believe they can. I believe it is possible to build a single management system for the critically, chronically, and permanently ill, retaining pluralistic financing but using a single management system and saving billions of dollars while we do it. I believe it is possible to create incentives that will cause a redistribution of health care resources to where they lay. I believe we are selling the American people and our institutions short by trying to avoid the hard choices that we face in the health care system. I have confidence that as a society, we will face it. I believe patients are willing to accept a greater responsibility for their health and their decisions if we will design benefit systems that encourage them to do so. I believe the employers will offer health insurance to people if they feel that the cost of what they offer is within their control and not subject to political maneuvering, lobbying or mandate. I believe providers will respond to incentives and redistribute and redirect resources to these areas of need and provide only medically necessary care if we create the right incentives. And finally, I believe insurance companies will be more consistent and more cooperative with providers if they believe the system has the right kind of incentives.

Facing these challenges is critical for us now before we have a crisis, and that crisis is surely to be upon us if we do not start to reform the system as the population ages and that population will consume three times as much health care resources and have dramatically higher long-term care needs than we have today. I am really confident, though, that these solutions can be found, and I thank you very much for allowing me to offer my thoughts, Senator Coats.

[The prepared statement of Mr. Lytle follows:]

PREPARED STATEMENT OF L. BEN LYTLE

Thank you Senator Coats.

You have assembled an impressive group of people here today. I feel very privileged to be a part of this program.

Senator Doug Hunt,
Representative Jeff Espich,
Carol Cowgill,
Mark Meiners, and
certainly you Senator,

have all played very key roles in implementing the innovative approach to long term care embodied in Senate Bill 107 in 1987. This type of public/private initiative is what we will need to solve the health care and long term care challenges that we face.

Indiana has been a leader in public private approaches to social problems. We are also a leader among the states in recognizing that reform is needed in our health care system.

As you know, I have been asked to Chair a Commission on State Health Policy created by Governor Bayh and the General Assembly. The Commission may provide a vehicle to implement meaningful reform and further serve as a pilot for elements of national reform.

My company, the Associated Group, is the 10th largest Health Insurer in the United States. We have a significant volume of business in 22 states, including some of the larger states like Texas, California, and Florida. I can tell you from our experience that while Indiana has only 2% of the nation's population, it is a microcosm of all the health care issues in the United States. And because of Indiana's tradition of public/private solutions, it could serve as ideal ground for developing meaningful national solutions.

With that background, I thought it might be useful for me to outline what I believe our most pressing changes are for the 1990's, and offer a perspective on how those problems might be addressed. My perspective as you might expect, is that Long Term Care can most effectively be addressed as part of overall health care reform, that it will be most readily available by a redistribution of resources.

Problems.

1. We have a health care system that provides superb quality of care but costs too much and is poorly distributed so that some people do not get the care they need while others get care that they probably don't need.

   What do I mean by this?

   I mean that we have more than enough doctors and hospitals to meet our needs, but they are often in the wrong place. The best parts of big cities and large communities have too much while rural areas and inner cities go wanting.

It means we have general hospital beds which we don't need and not enough long term care beds which we do need.

It means that we have a long term care system that serves only the poor, but leaves the middle class seriously at risk.

It means that 15-25% of all treatment rendered is medically unnecessary, rendered because of inadequately educated providers and patients and because it gets paid for whether necessary or not, while 30 million people go without adequate health insurance coverage.

2. We have not yet as a people squarely faced the challenges of the future in health care and made mature choices about the balancing the amount and quality of health care we wish to provide and how much we are willing to pay for it, and about the balance of payments between individuals and government.

   People are looking to quick, painless solutions. Some want to adopt other countries systems, without understanding the price those countries pay in rationing of care and inconvenience to patients and without recognizing the inherent differences in our societies and the related social problems.

Everyone wants to blame everyone else for the problems and shift the responsibility to someone else, so that they do not have to change. Everyone involved in the health care system is responsible for the problems that it has:

- Providers render medically unnecessary care to increase their incomes, to avoid litigation, or because they lack adequate training. They raise their charges based upon their particular needs more than as a response to increased costs or competition.

- Employers and other payors, despite the rhetoric over costs, have deepened and broadened health care coverage for employees without adequate cost-sharing. The result has been a 13% annual average increase in employer health care expenditures over the last decade.

- Insurers and administrators have ventured deep into medical management, often without adequate credentials, frequently complicating conditions rather than improving them. Insurers have entered and abandoned the health insurance business at will, aggravating the cyclical nature of the industry.

- The public has high expectations of the health care system without an acceptance of the cost that must be borne to meet the expectations. We avoid responsibility for the difficult moral choices we must make. We pursue high risk behavior without accepting the cost consequences to our health.

- Government has tinkered in the health care system rather than coming to grips with its economic and moral reality. It has yielded to special interests, mandating benefits and implementing halfhearted and ill-directed regulation rather than serving broad consumer interests.

What then, can we do to reform the health care system, to get to do what we want to do.

1. We must restore economic discipline to the system. Supply and demand must be allowed to work. People must be economically accountable for the decisions that they make.

2. We must redistribute the health care resources we have to the areas of need. Away from general hospital inpatient beds to long term care and home care, away from excess capacity in one geographic area to another.

3. We must concentrate on managing the concentrations in the health care system. A small percentage of the population consumes a bulk of the health care resources. 3-5% consume 50%, 10% consume 75%. A few hundred diagnoses likewise out of thousands. Even certain geographical subdivisions.

4. We must change attitudes. We have got to step up to this challenge the same way that we have others.

5. We have got to provide every person in this country a minimal level of care necessary to allow them to function and have a meaningful life. If we do the other things I have mentioned, this is possible.

So can these rather broad imperatives be put into action?

I believe that they can.

1. I believe it is possible to build a single management system for the critically, chronically, and terminally ill, with pluralistic financing, and save billions of dollars while increasing the quality of care.

2. I believe it is possible to create incentives that will cause a redistribution of resources to where they are needed.

3. I believe we are selling the American people and our institutions short by trying to avoid the hard choices we face in the health care system. I have more confidence in us as a society than that.

4. I believe patients are willing to accept greater responsibility for their health and their decisions, if we will design benefit systems that encourage them to do so.

5. I believe employers will offer health insurance if they do not feel the cost of what they offer is subject to political maneuvering and provider lobbying.

6. I believe providers will respond to incentives to redistribute and redirect resources and to provide only medically necessary care.

7. I believe insurers will be more consistent and more cooperative with providers if they believe the system has the right incentives.

Facing these challenges is critical for us now, before we have a crisis that is surely on its way as the population ages, and that population consumes three times as much health care resource and will have dramatic long term care needs.

I am confident that solutions can be found. I thank you for allowing me to offer my thoughts.

Senator **Coats**. Ben, thank you very much. We will have some questions for you. I think what we will do is have each of the panelists submit a presentation and then open it up for questions and discussions.

Mark, thank you for coming today. We appreciate your input.

Mr. **Meiners**. It is really my pleasure to be here today. I want to give you a little bit of background on myself. I am an associate director of the Center on Aging at the University of Maryland, and I am also director of the Robert Wood Johnson Foundation Program to Promote Long-term Care Insurance for the Elderly. This was a position I took on 2 years ago after nearly 17 years in the Federal Government, having worked the last 10 years in the Department of Health and Human Services. So that is my background.

I am particularly pleased to be here today and want to acknowledge the support you have given us in this program because it is extremely significant. The absence of adequate insurance funding for long-term care remains a topic of considerable debate in the context of seeking improvements to our health care system. Medicare, as we all know, is the major source of financing for health care for the elderly, but it does not cover long-term care. Medicaid will continue to be the source of substantial amounts of coverage for long-term care but only after people have become impoverished. In effect, people must spend their life savings if Medicaid is to become their long-term care insurance program.

This all-or-nothing approach to insurance from the public side has troubling implications for both the individual and for public payers, and it has so for many years. The cost of long-term care services under Medicaid and the number of individuals in need of service is growing rapidly. As the costs rise, so does the pressure to reform long-term care financing and delivery systems. Indiana was one of the first of several States that have responded to this pressure by proposing their own initiatives designed to help make private long-term care insurance appealing and affordable to the general public.

In response to these initiatives, the Robert Wood Johnson Foundation has given planning grants to 8 States as part of the foundation's program to promote long-term care insurance for the elderly. The 8 States—the other States in addition to Indiana are California, Connecticut, Massachusetts, New Jersey, New York, Oregon, and Wisconsin. The purpose of the program is to provide States that have demonstrated a commitment to reforming long-term care financing with the resources to investigate the potential role of public/private insurance partnerships in long-term care financing. While States envision different types of partnerships, the goals for all States is to develop long-term care insurance options that are coordinated with public program benefits to help elderly consumers avoid having to become impoverished simply because they need long-term care services.

There are a number of common elements that we have discovered in all the programs around the country that are in this partnership effort. First of all, all the programs are seeking to design long-term care insurance options that are affordable to a broad spectrum of the population. This includes low income people as well as middle and high income people. Efforts to accomplish this are specifically geared toward things such as product designs which are limiting coverage to a set of benefits that are affordable to individuals and considering premium subsidies as well. All the programs are considering case management services to make sure the consumers are aware of their options and the dollars that are in the programs are used as efficiently as possible.

In addition to that, each State is considering a major public education and information campaign to make sure people understand the risks they face and the options that are presented to them through the programs. In addition to that, we are pursuing high regulatory standards so that each of the insurers who offers a program in these States will be encouraged to provide products that are the maximum protection we can give at a very good price. So those common elements are part of the program throughout the States.

The partnership program contains incentives for maintaining informal supports which we feel are very important and also allows elderly a voice in determining what kinds of insurance they would prefer and how much they would like to pay for it. The emergence of private insurance options at work in partnership with State Medicaid programs can be viewed as complimentary to the improvement of the details of some of the many social insurance ideas that are being proposed on Capitol Hill. The experience of the States, we feel, in creating the administrative partnership financing programs could provide the basis for further reform of the current system or for the creation of national insurance types of strategies, if that is the way we feel we should go in the future. The demonstrations that we want to plan under this program will provide valuable experience, data and insights that will be useful to all our planning for long-term care.

And I particularly want to thank you for your efforts in seeking waiver legislation so that this program can go forward. It was a particular boost to us at the end of last year, and we look forward to working with you more this year to see that this opportunity is given to us by the Department of Health and Human Services.

[The prepared statement of Mr. Meiners follows:]

PREPARED STATEMENT OF MARK R. MEINERS

The absence of adequate insurance funding for long-term care remains a topic of considerable debate in the context of seeking improvements to our health care system. Medicare is not designed to cover long-term care. Medicaid will continue to be the source of substantial amounts of coverage for long-term care but only after people become impoverished. In effect, people must spend their life savings if Medicaid is to be their long-term care insurance program. This "all or nothing" approach to insurance from the public side has had troubling implications for both consumers (primarily the elderly) and public payers for many years.

The costs of long-term care services under Medicaid and the number of individuals in need of services is growing rapidly. As the costs rise, so does the pressure to reform the long-term care financing and delivery system. Indiana was one of the first of several states that have responded to the pressure by proposing their own initiatives designed to help make private long-term care insurance appealing and affordable to the general public.

Planning Insurance Partnerships

In response to these initiatives, the Robert Wood Johnson Foundation (RWJF) has given planning grants to eight states (California, Connecticut, Indiana, Massachusetts, New Jersey, New York, Oregon, and Wisconsin) as part of the Foundation's Program to Promote Long-Term Care Insurance for the Elderly. The purpose of the program is to provide states that have demonstrated a commitment to reforming long-term care financing with resources to investigate the potential role of a public-private insurance partnership in long-term care financing. While states envision different types of partnerships, the goal for all states is to develop long-term care insurance options that are coordinated with public program benefits to help elderly consumers avoid having to become impoverished because of their long-term care needs.

Frequently Raised Issues

Over the course of our program development a number of issues have arisen concerning public/private long-term care insurance partnership projects being proposed by eight states participating in a Robert Wood Johnson Foundation program. The following are statements which have been made and a summary response to each. Those interested in more detail on any of the issues are encouraged to contact The National Program Office or any of the participating states.

1. Long-term care is a national problem only amenable to a national solution.

   Ultimately, a national long-term care system may be in the country's best interests, however, we are not now in the political or financial position to mount such a program. Long-term care financing and delivery is currently administered by the states through a variety of programs including Medicaid, rate setting, certificate of need and various licensure and quality control programs. States have been the locus for innovation in long-term care for a number of years. State government is the only entity with any substantial experience with the administration and financing of long-term care programs, and is also responsible for the regulation of insurance. Financing reforms should be built on the experience of those states which have lead the way in establishing better non-institutional and institutional programs. Denying these states the opportunity to experiment with an issue of such vital importance is to reject their extensive experience and prolong the status quo.

2. Elders would prefer the federal government to establish a program for long-term care in which everyone must participate.

   While this may be the vision of some, public will, even among elders, is not at all clear on the best way to proceed. State efforts to create public/private insurance partnerships have gotten strong support from the elder community. Furthermore, the resistance to the Medicare Catastrophic Act demonstrates that elders like to retain control over decisions about how much insurance they should purchase. The state specific approach of the program respects elder's desire to choose and allows for the development of care delivery options which are consistent with the traditions and customs of the different areas in which elders live, while operating within the reality of present economic and political conditions.

3. Long-term care insurance products are inadequate and will not provide those benefits which elders want and need most.

   A major goal of all the state projects is to improve the value, and quality of protection offered through insurance products. Partnership programs in all the states will include standards at least as rigorous as those suggested by the National Association of Insurance Commissioners. State participation with insurers in this partnership is predicated on improvement of the dollar value and benefits offered for long-term care. Many of the states are designing high quality products which will be offered to state workers and retirees.

4. Many older people cannot afford insurance.
   Making insurance affordable has been a major goal of the program. All of the states are interested in the greatest level of participation possible. Of particular interest is the group most likely to spend down their income and assets to Medicaid eligibility levels. As is currently the case, some elders have resources too low to afford insurance. This group is better off continuing to rely on the existing Medicaid system. By reducing middle-class dependence on Medicaid, there should be more funds available for those with low incomes.

5. Persons with a disability or those at high risk of needing long-term care will not be eligible for the program.
   Insurance programs by their nature are risk pools, and not payment mechanisms. They are designed to provide assistance for those who are at risk, but not those currently using services. Central to an insurance program is a pool of persons paying premiums at somewhat equal risk of needing services. States are assuring that insurers accept a fair share of the risk. Allowing those already using services to participate would erode the risk pool. States have programs for disabled persons and those currently using long-term care. The demonstrations are intended to facilitate improvements in the existing financing and service delivery programs, not to replace them.

6. Young persons would not be able to participate in the program.
   This is simply not the case. Persons less than fifty years of age will certainly be able to buy insurance from a number of different companies and possibly through a group policy at their place of employment. When purchased at younger ages long-term care insurance rates tend to be less costly and much more affordable. The purchase of long-term care insurance by younger persons will be encouraged in state educational campaigns which will be conducted as a part of the program.

7. Insurance payments towards community based care will not count toward protection of assets.
   Again, this is simply not the case. Community based care will of course count towards protection of assets. Insurance coverage of

non-institutional long-term care is a critical part of the program development strategy. In fact all states are designing plans which emphasize community based care, case management, and allowing elders to remain at home for as long as possible.

8. Some individuals with insurance may still become impoverished.
   If individuals choose an appropriate combination of benefits and premium in relation to their income, they will not become impoverished. The program will offer elders an opportunity to become eligible for public long-term care benefits without first having to impoverish themselves in exchange for purchasing a specified amount of insurance protection. Beyond the minimum level of insurance, individuals will be free to choose the amount of insurance that is appropriate for their income and asset position. We anticipate that a variety of insurance options at corresponding premiums will be available for purchase, and that states will assist elders in understanding and choosing among their options. Elders in a variety of income and asset positions will be able to assess their own risk and determine how best to arrange their coverage.

9. Some elders participating in the program may still have to meet the Medicaid income test.
   States are currently in the process of determining how income will be treated in the program. Some will continue to count income against the nursing home cost once an individual becomes Medicaid eligible. Even if they are contributing their income, they will have been afforded some amount of asset protection. These assets can then be used to augment their care in whatever manner they choose. The only persons who will not become Medicaid eligible will be those with income high enough to cover the entire cost of care.

10. Medicaid benefits are inadequate and institutionally biased.
   States participating in the program are on the forefront of providing long-term care services in general and especially community based services. All of the states are committed to coordinating their existing non-institutional network of services with the institutional system. The result is a system which enables elders to remain at home for as long as possible. These states have as much or more experience with community based care than do insurers or other government payers, making them

an ideal location to develop the necessary non-institutional infrastructure.

11. The partnership programs will cost Medicaid additional funds and thereby deprive the truly needy of services.

    The programs will not increase state or the federal expenditures under Medicaid. The design of the proposed demonstrations, as well as the enabling federal legislation, are by definition at least budget neutral. The participating state governments are not in the fiscal position to undertake new expenditures. Simulation estimates project that states can achieve break even budget results, and in some cases, savings. If savings can be achieved, there will be additional resources available for the Medicaid program.

12. This program will make it harder for Medicaid patients to get access to needed services.

    The existence of different payment rates for different groups of patients provides an incentive for providers to discriminate. Short of an equalization of all rates this incentive cannot otherwise be entirely mitigated. Some states in the program already have controls over the rates which providers are allowed to charge private paying patients. For the others the goal of the program is to enroll as much of the elderly population into one group whose care is reimbursed at roughly the same rate as possible. To the extent that the programs are effective in enrolling elders and assuming that insurers explore negotiated rates, the amount of discrimination should be reduced under the program.

13. If payment rates aren't limited to what Medicaid reimburses, the program could cost the states more.

    The basic premise of the program is to allow those who would have depleted their assets to become Medicaid eligible without facing impoverishment. This is done through a risk pooling mechanism which uses premium revenue rather than personal savings to pay for care. While individuals will not face losing their savings, Medicaid liability will not increase over what it would have been in the absence of insurance. As Medicaid will not be responsible for any additional days of care than it would in the absence of the program, the rate used by insurers is irrelevant to Medicaid costs. There is, however, the potential for insurance benefits to last longer than personal saving, which will return a savings to the states by delaying the commencement of Medicaid payment.

14. Insurance programs will erode public support for the Medicaid system.

    The proposed demonstrations have the potential to increase both the visibility and the support for an improved Medicaid program. The greater acceptance of the Medicaid program as an important ingredient in the insurance partnership will improve the status of the program as a political and budgetary priority.

15. Simulation estimates forecast that the program could lead to increased Medicaid costs.

    All of the states involved in the project have been working on the development of forecasting tools which will assist in the analysis of various components of the plan. This area has received a great deal of time and attention due to local budget constraints and language in the federal legislation which requires the programs to be budget neutral. A variety of forecasting methods are being used which incorporate home care and state specific demographics, utilization and cost estimates.

An analysis of Connecticut's proposal was done using the Brookings/ICF simulation Model. The results show that the program not only breaks even, but affords modest savings of 1% per year in the first 5 years, and as much a 4% per year in the years 2016 to 2020. These savings are important to the program because they will enable Connecticut to increase its efforts to expand program enrollment, especially among low-income elders. The following table summarizes these results:

Connecticut Long-Term Care Partnership Simulation Results

	Private Market	CT Partnership
Minimum Annual Premium		
in 1986 at age 65	$968.00*	$427.00**
Percent of Elderly Insured		
by 1995	16.6%	36.6%
by 2020	19.3%	45.2%
Percent of Nursing Home Bill Paid (<1% at present)		
1991 - 1995 Average	2.8%	8.9%
2016 - 2020 Average	5.8%	19.3%
Effect on National Medicaid Budget		
1991 - 1995 Average	0	-0.7%
2016 - 2020 Average	-0.6%	-3.9%

* Private market rate is for a 3 yr policy. ** CT Part rate is for a 1 yr policy

The above simulation results are based on the following assumptions:

- Policies will be purchased in 1 year increments by persons aged 65 and over according to the following schedule:
  - A 1 year policy will be purchased if the person has $25,000 in assets (including their share of home equity) and the policy costs less than 5 percent of income.
  - Additional 1 year riders (for up to 5 years) will be purchased for each additional $25,000 in assets the person has as long as they can afford these riders for less than or equal to 5% of income.

- Premiums are adequate to cover 80% of the charges in the typical US nursing home.

- If a couple can afford only one policy, the couple will buy one policy randomly assigned to the husband or wife.

Senator Coats. Thank you very much, Mark.

Doug, thank you for taking time this morning. I know you are in the middle of a session and it is probably time you do not have, but we appreciate you coming over here and testifying.

Senator Hunt. Well, the committee votes are roll call votes, but usually they are not quite as important as floor votes. And I will miss a few, but I think it is well worth it to have an opportunity, first of all, and I think maybe even foremost, to thank you as well for your efforts and to discuss a little bit the need to bring that issue to a closure, which perhaps is better addressed to your colleagues in the House. But I cannot emphasize enough the critical nature of the Federal demonstration and support that will be needed certainly in Indiana and many of these other States, all of these other States, to carry off the challenge that we have undertaken.

I came to this issue prior to 1987 probably from as close to the same perspective as you have as anyone in the room, that is as an elected official, simply because I saw firsthand the problems, literally door-to-door in some cases, that people have in dealing with long-term health care needs, particularly those in the middle income and lower income ranges. And I felt that we could not design a more horrifying way to confiscate what somebody has earned over a lifetime than the policy that we really still have in place, although it has been mitigated somewhat by the changes in Medicaid eligibility as part of the Catastrophic Act. So as an elected official, I felt duty bound to try to figure some way within the reality that we have to deal with to address this situation, and that included a recognition that private dollars already are relied on in an extremely heavy way to deal with these costs. It is just that they are often met—they are often used in a situation which is sudden and traumatic, rather than one that can be planned upon and anticipated, at least the resources to meet the need if it arises can be anticipated.

So in Indiana what we have tried to do is to basically encourage the development of private insurance policies that will be tied to Medicaid in the sense that a person who needs long-term care that is provided by their private insurance will, if their needs extend beyond what that insurance covers, be eligible for Medicaid without having to spend down to the standard Medicaid level, and as a result, hopefully will have a far more secure and comfortable future should they run into the unfortunate situation of needing long-term care.

So in Indiana what we are trying to do is to take on what I think is a very big challenge, which is how do you relate public and private programs, public and private dollars, all along the line, not just at the outset. And we are attempting to define what kind of insurance policies will qualify, trying to strike a balance between making sure that those policies provide these services that are required and that justify this tie-in with Medicaid, and yet not stifle invasion in the private market. Because there is always room for improvement if we allow it to come about.

The other feature, then, is that as I said, if the private care is needed and the benefits are exhausted, then Medicaid will kick in and pay for the long-term care cost. As you know, Senator, we also have the Choice Program which was established in Indiana and is growing quite rapidly, and there is a great need to try to integrate that as well into the picture. The reason, I think, that we are taking a prudent approach is that we—I believe it is a prudent approach.

We are now focusing on an approach called variable asset protection. I had hoped originally that we could come up with a kind of—what I call kind of a basically long-term care policy that would be easy to communicate to folks and would be affordable. Maybe we can still do that, but right now it looks like the more promising realistic route is to allow policies to be sold which allow a person to choose to protect various levels of assets. This will, frankly, allow us to avoid a tough problem we ran into, which is the price. If you allow just one basic level of coverage, the premiums may be such that you are cutting out a lot of folks, and that means that what I call the equity issues, the fairness issues, become almost insurmountable. So I guess in my own mind I have had to make kind of a compromise there, but hopefully it is one that we can grow with and develop from.

Also, I think it makes it somewhat easier for us to address the fiscal impact on the State and Federal Medicaid dollars of the variable asset approach. There is sort of a self-regulating nature to that that I hope will make it easier to demonstrate to Federal officials that a waiver is called for under the terms that you have put in the bill, namely that it be revenue neutral.

And then also we have a very tough challenge, as I said, in integrating this program with the private sector. As I said, the policy has to be designed so that it provides the consumer what is called for but also allows for invasion. We have problems not yet resolved as to determining when a person should be eligible for benefits once they are on the policy. When do they start drawing down these benefits? And then finally there is a big problem or an issue of administrative coordination. If a person is drawing down their private benefits, how do we make sure that only those eligible benefits are counted toward this amount which—after which that is exhausted a person can move on to Medicaid? So we really are looking to work so closely with the private sector that it is, I think, almost unprecedented certainly in health care policy and in many other areas as well.

And finally, I guess I would like to say that the demonstration nature of this program is one which I would hope your colleagues in Congress would be responsive to as they have been in the Senate, and that is because this is such a big area, it is only, I think, prudent for us to try some alternative ways. And you have 8 States that have taken it upon themselves to take some initiatives from which we all can learn. Obviously, this is a real legacy of our Federal system. As you know, the States have been called the laboratories of democracy, and that is what we are, I guess, asking to serve as in this case.

And finally, the reality that first got me into this area had two parts. One was the fact that there was a need. The other is that there did not seem to me, as a politician, to be broad-based support for another fully funded Government program, and I guess I would point to—as recently to the reaction to Senator Moynahan's proposal on Social Security to indicate the response and interest that it is getting, I think, reflects somewhat the fact that Americans, at least not yet, have been shown a proposal for general Government programs that I think they are willing to support. And until they do, we have to find ways to make the best use of the resources that are available, and I think Indiana and these other States are in the forefront of that.

So finally, I would just close with maybe a couple of tactical suggestions, because the effort that you have initiated in the Senate has to be concluded by concurrence in the House. And while our House Delegation in Indiana has been very supportive, I understand that as policy, the way the House is set up, the channels tend to get narrow when you get into specific areas; and in the health policy area, we may not find at this point the broad support that is needed. So I would certainly encourage you, and will stand ready to support you, with Members of the House to tell them the same story I have told you today and how critical it is that the Federal Government enact this waiver because we cannot start this program on 100 percent State dollars. It just cannot be done financially. We need the waiver, and I think that the Federal Government needs the waiver as well, in order to make good decisions in this critical area in the years ahead.

[The prepared statement of Senator Hunt follows:]

PREPARED STATEMENT OF DOUGLAS HUNT

The enabling legislation for the Indiana program was passed unanimously by the Indiana General Assembly (SEA 107 of 1987), possibly because this is a win-win-win program....for the state and federal government, for elderly consumers of long term care, for the taxpayers of the state, and for private insurers and private providers of long term health care.

Following passage of this legislation, Governor Robert Orr's and Governor Evan Bayh's administrations have worked diligently to design and implement the program in partnership with the private sector, with guidance and consultation from Dr. Mark Meiners, and as one of the eight states participating in the Robert Wood Johnson Foundation's Program To Promote Long Term Care Insurance For The Elderly. We are attempting to create an innovative program which coordinates public and private sector financing of long term care, specifically by integrating private insurance coverage with the state Medicaid program.

In order to accomplish this objective, the State needs authority from the federal government to waive the asset spend-down requirements of the Medicaid program. We would like to thank Senator Coats for sponsoring Senate Bill 1998 which provides this authority and we are very gratified that his bill was passed by the unanimous consent of the U.S. Senate in November, 1989. If the bill is passed by the U.S. House of Representatives this year, it will provide the authority needed for Indiana and eight other states to implement demonstration programs like the Indiana Long Term Care Insurance Program.

As per your request, Senator Coats, I will summarize very briefly the problems and the solutions envisioned in the Indiana Long Term Care Insurance Program, with special emphasis on the affordability, equity, and consumer protection concerns associated with the program.

As you know, historically most long term care has been provided in nursing home settings at an average cost of about $22,000 per person per year. Nearly half of the total cost of nursing home care has been financed out-of-pocket by individuals and their families. State Medicaid programs have financed most of the balance of costs, but only after families have exhausted nearly all of their financial resources. Only a small portion of the total nursing home costs -- only 4% in Indiana -- have been financed by Medicare or by private insurance. Under the current system, the middle class elderly often become impoverished by the costs of long term care and find themselves on Medicaid, a program originally intended for the poor. Consequently, major and growing portions of state Medicaid budgets -- nearly $500 million a year in Indiana -- are devoted to financing long term care.

Long term care financing issues are becoming even more important as the American population grows older; for example, the number of Americans over the age of 85 - an age group particularly in need of long term care services - is expected to grow three to four times as quickly as the general population. Up to 40% of all elderly Americans are likely to spend a portion of their lives in a nursing home.

For these reasons, the State of Indiana has sought to find a more rational and humane method of financing long term care for the elderly, one that builds and improves upon the current financing system and one that can be implemented efficiently and effectively for Indiana's citizens. We know from national attitude surveys, from an Indiana University survey of the elderly population, and from statistics on the income and asset levels of the elderly, that as many as 50% to 75% of our citizens are willing and able to pay for private insurance policies that meet their long term nursing home and home health care needs.

The Indiana program is geared not toward people already eligible for public programs but toward people at risk of becoming eligible for public programs by spending all of their resources to the point of impoverishment. The Indiana program is one of several programs being undertaken by the State to reduce the traditional bias in favor of financing institutional care, in this case by requiring that qualifying insurance policies must include home health care as well as nursing home coverage.

Indiana's public and private officials have been working for the past year to design a program that complements the spousal impoverishment provisions retained in the Medicare Catastrophic Coverage Act.

The Indiana Long Term Care Insurance Program has been designed to ensure fiscal neutrality and ease of administration for the state, to foster insurance industry flexibility and innovation in long term care product design, and to maximize both the affordability of insurance and the opportunity for consumer choice among a wide array of long term care insurance products. Consumer protection is provided through a set of minimum standards that insurance products must meet in order to qualify for participation in the Indiana Program. These standards exceed the guidelines recommended by the National Association of Insurance Commissioners and adopted as rules by the Indiana Department of Insurance.

In order to serve the broadest possible range of income groups in the simplest and most equitable manner, the Indiana program is designed to provide Medicaid asset protection equal to the amount of insurance benefit payments used after the age of 65 for Medicaid eligible long term care services. Consumers have the option of purchasing a qualifying policy with the amount of insurance coverage (and asset protection) that they believe they need and can afford.

After depleting insurance benefits and becoming eligible for Medicaid, insured individuals will contribute income toward the cost of care in the same manner as other Medicaid eligible individuals. For services covered in insurance policies but not yet covered by the Indiana Medicaid program (e.g., certain home care services), eligible consumers may apply to the state for participation in other public programs which do provide these services (e.g., CHOICE and other home care programs administered by the Indiana Department of Human Services).

As currently designed, the Long Term Care Insurance Program's sliding scale approach to asset protection will provide maximum consumer choice and consumer savings, while enabling the state to assure that Medicaid expenditures with the program will not exceed Medicaid expenditures in the absence of the program. No one will become eligible for Medicaid earlier than they would have in the absence of the Long Term Care Insurance Program. The program should result in public savings for individuals whose insurance coverage exceeds the value of their assets, because insurance will finance care beyond the point at which these individuals would have spent down to Medicaid eligibility.

Current Indiana statute provides that in order to qualify for the Long Term Care Insurance Program, insurance policies must provide coverage for at least twelve months. This twelve month minimum has merit for three primary reasons: first, premiums are affordable to a majority of people for this level of coverage; second, the length of stay in nursing homes is less than one year for a majority of people (63-73% depending on the source); and third, a majority of the spend down group (86% according to Indiana statistics) spend down within one year.

Additional minimum standards have been adopted by a task force which includes consumers and representatives of the insurance industry. Among these consumer protection standards are the following:

1. Insurers must clearly disclose prior to sale and with all policies the availability of state sponsored counseling, consumer education, complaint handling and appeal mechanisms.

2. Policies must guarantee consumers the option of buying inflation protection or must provide another mechanism by which the value of coverage will keep pace with changes in the cost of care.

3. Policies must cover home health care, care in skilled nursing facilities and care in intermediate care facilities, and may cover additional services including but not limited to respite care, adult day care, custodial care and a variety of other home care services.

4. Coverage must include treatment of Alzheimers disease and senile dementia.

5. Prior hospitalization or institutionalization may not be used as a condition of eligibility for benefits in a less restrictive setting.

6. Policies must be guaranteed renewable.

Insurers have agreed in principle to identify and provide the state with the types of data needed to administer the long term care insurance program and to evaluate its effectiveness. For example, insurers have agreed specifically to track the characteristics of persons denied coverage due to underwriting. After the first two years of operating the Indiana Long Term Care Insurance Program, the state, in conjunction with insurers, will evaluate the need for additional public/private approaches to serving persons with limited access to coverage due to economic or health status factors.

Several task forces currently are working in Indiana on resolving implementation issues related to coordinating public/private service delivery for the Long Term Care Insurance Program.

For example, one task force is designing the consumer education and information component of the program, which we consider to be one of the most important functions the State will perform in this public-private partnership. While the State still is in the planning stage for this part of the program, plans to date call for installing a state toll-free long term care insurance hot line, for developing public service announcements and brochures, and for working with Indiana's area agencies on aging and senior interest groups to develop a network of trained persons knowledgeable about long term care generally and about the Indiana Long Term Care Insurance Program specifically. Indiana statute provides that long term care counseling will be available to persons age 65 and over though the Welfare Department or the Department of Human Services. In addition, the Indiana Department of Insurance is expanding its consumer education and complaint handling capabilities and plans to develop a volunteer network of technical assistants.

If granted a waiver, the State of Indiana expects to demonstrate that insurance is a viable method of financing a greater portion of long term care expenses than has been the case to date. The state seeks to demonstrate that it can simultaneously enhance the quality and affordability of long term care insurance coverage available to its citizens, reduce financial hardships for the elderly, and offset future public expenditures for long term care.

The Indiana approach can improve the well-being of hundreds of thousands of elderly persons, making it possible for them to plan ahead to meet their long term care needs without fear of impoverishment. Today, as we begin a new decade and prepare for a whole new century, we believe that this demonstration program will yield answers to many key implementation, marketing and utilization questions and will provide critical data needed to inform the debate over a national approach for financing long term care.

Thank you, Senator Coats, for providing the State of Indiana with this opportunity to address the Senate Subcommittee on Aging.

Senator COATS. Thanks very much, Doug. It was a bipartisan effort that got it past the Senate, and it is going to be a bipartisan effort that will get it past the House, so I will be happy to work with you—with our delegation in the House to get that accomplished. And hopefully we can do that fairly soon so we can get moving with the program.

Jeff Espich, Representative Jeff Espich, sent his regrets. He has three committee hearings this morning in the General Assembly and sends his apologies for not being here.

I want to also recognize Carol Cowgill—raise your hand there Carol—who is coordinating this program in the State, and I look forward to working with you in the months ahead to make this program a reality and demonstrate the effectiveness of it.

I have some questions if I could ask for the panel, and to the extent that we have time, I'd be happy to open them up to the audience also. I want to get as much participation in this as possible. If I could just start with a couple of questions, Ben, you indicated that some single management system might be necessary to coordinate all of this, and I wonder if you could elaborate a little bit on that as to what type of system are you talking about and who are we talking about in terms of managing this system.

Mr. LYTLE. The——

Senator COATS. Again, if you could pull that mike to you.

Mr. LYTLE. The population I am referencing, again, is the fairly small number, 3 to 5 percent of the population, that in any given year is critically, chronically, or terminally ill. Those folks today—one of the things I should say that has come out of the last tenure that has worked well has been something called catastrophic case management, and essentially what it is is like a case worker to work with the physician, the family and the patient in a purely volunteer effort to say that here is a certain amount of funding we have for certain kinds of treatment. How can we best get that done? And that case manager when it is a private insurance program essentially has the authority to suspend the normal rules for what is and is not paid for in order to treat a patient.

So how that would work, for example, is in the past if a particular type of treatment was not covered under an insurance program, then the person—and perhaps it was only covered if the person was in a hospital—in order to get that treatment, they had to stay in a hospital. Under a case management program, if the case manager determines that the best way to treat that person is at home but they need to build a wheelchair ramp into their home, as long as they can demonstrate, the case manager can demonstrate, that it is equally or less expensive, they will go back to the insurance company and say, "I think we ought to pay for this if the family wants to do it," and it is done that way. That has been an extremely successful program. The problem is—it is not fully implemented today. Some private programs have it; some do not have it. Some government programs have it; some do not.

What I am proposing is that we identify all the people who are catastrophic, critical, or terminally ill and place them into a single management system. By that I mean that all the Government programs, Medicaid, Medicare, the high risk pools, would use the same management approach for the critically, chronically, and terminally ill, as would private insurers. The payment mechanism can remain the same. And why I say a single management system is because there is where you can develop the expertise and the leverage and the necessary volume to really manage those patients efficiently.

Senator COATS. Who do you envision administering this management system, the State? Private entity like Blue Cross/Blue Shield?

Mr. LYTLE. I would put it out to bid. I would develop the mechanism to bring everyone into the management system, and then I would bid it out as you would any other well-conceived procurement plan. You would bid it out to whoever could best operate it, demonstrate both the quality and the cost effectiveness.

Senator COATS. You talked about the lack of equal distribution in terms of facilities and services and so forth, yet we find across the State of Indiana—and I am sure it is true in other States across the country—a lot of empty beds in rural hospitals. Now, I kind of got from your testimony the fact that we had a concentration of services available in urban areas, particularly suburban areas, but not in rural areas. Yet what accounts for the empty beds and the struggles of our rural hospitals to provide service?

Mr. LYTLE. I think I first of all agree with your point. I think the shortage we have in many of the rural areas is of the right kind of services. You often do not have enough primary care physicians in rural areas, but yet we have excess hospital beds. And a lot of that is driven by the fact that I think our reimbursement system for the past 20 years has tried to create general hospitals in every community, and that may not be feasible in the next 20 years. We may have to have more specialization in rural areas. Likewise, we have to create incentives that make it meaningful and worthwhile for someone to go all the way through medical school and then practice in a very small town. Today it may not be economically rewarding, and so everyone migrates to the cities. We need to create the right incentives for people to practice in the small communities. But we do not need—you are absolutely right—more general hospital beds in small communities. It is just not feasible, I do not think, in the next 20 years.

Senator COATS. Mark, I wonder if you can elaborate a little bit on the time table for the Robert Wood Johnson studies. When do you hope to have enough information back so that you can make some policy recommendations as to what directions to go and how successful these programs are? Have you established a specific time table?

Mr. MEINERS. Yes. First of all, let me say that the staging of this program is one that we have viewed in two phases. The first phase is a planning phase that we are involved in right now. All the States have been working on these programs for probably—some as much as 2 years, some maybe a year and a half. The planning grant phase was run for about 2 years. After that planning phase has been completed—and for some States it has been completed, Connecticut in particular—those States have the option of applying for the next phase, which is a demonstration phase.

During the demonstration phase, which we expect to go on for about 6 years, we expect to learn a number of things early on, that is, how does the partnership work? How do public programs that are existing in the State, how are they really coordinating with the efforts of the private insurance market? Who is likely to buy this kind of insurance? How effective are the incentives? How effective are the educational campaigns in getting people to truly understand the risks that they face and the features of the program? Those are all lessons that we can learn early on.

Another important element that we feel we need to learn about, however, is how do people behave in terms of their utilization in the face of owning an insurance policy. Insurers have for some time worried that they do not have enough information to really effectively plan the products or certainly price the products; and we think because of that, often times the products are priced too high. Because of this kind of a program, we expect to be able to get data that otherwise would be proprietary information and be able to use that data to both refine the program and to better understand how people behave in the face of insurance so that if there is this opportunity to reduce premiums because utilization is not as high as is expected, we will have the information to negotiate those kind of reductions. So it is a phase learning process that we expect to take place over a 6-year period.

Beyond that, we expect, frankly, that the program will catch on in other States and not really be per se a test. We, however, expect that we would want to be monitoring it over time because, frankly, none of us can predict what will happen in the future with respect to long-term care.

You noted changes in supply features, hospital beds that become vacant. We know that there is around the country, in general, a limit on nursing home beds. We know that home and community care is only beginning to expand. How these changes in our service structure will affect the use of service is something we simply cannot predict right now. So it is important to have this kind of structure in place to be able to monitor and refine what we are doing over time.

In the private insurance market and in public programs, we do that in a manner of fashion, but it is not as systematic as it needs to be, I would suggest, particularly in our regulation and review of private insurance products. It is more on a year-to-year basis. This kind of program will allow us to put in place the kind of management information system that will allow us to understand for a long period of time how the program is evolving so that we can make the fine tuning refinements and keep it a viable option for individuals over time.

Senator **Coats**. You referenced that there may be a need for regulatory standards in terms of establishing these kinds of program. Who do you suggest should prescribe those standards? Should that come from the Federal Government? Should the various States set up their own standards? Is it a cooperative effort with the insurance providers? How do we go about doing that, and who should do it?

Mr. **Meiners**. Well, traditionally insurance regulation is a State function, and in this particular area, I think there are a lot of State- and local-specific features that need to be reflected, so personally I think that keeping it at a State level is probably the way to go.

The National Association of Insurance Commissioners has prescribed some national guidelines that States can follow, but it is on a voluntary basis. It seems to me that a State-specific approach allows for the kind of flexibility that we need. There clearly is guidance that can be provided from a national level, but I would say guidance is probably all that is necessary. I think the States have an experience—and with the kind of structure we are setting up, frankly I would expect that the States would have even a better base of information to work from. And we know full well that the kind of information will be different across the State simply because the partnerships will be different and the service structures and traditions of States are different. So from my perspective, a State-based regulatory system will make sense in this area.

Senator COATS. Senator Hunt, on that last point, can you enlighten me a little bit about your perspective or our State's involvement in setting these standards? Has there been discussion under way as to how that ought to be done and how these ought to be established?

Senator HUNT. Well, we have given a great deal of discussion to what I would call the consumer protection side of things to make sure that any policies that do qualify for this, what I think is—will be a significant advantage in marketing their policies to be able to tie it into Medicaid, that they have features with respect to protecting the consumer's interest. And specifically some of the areas—Mark can address them better than I can—but in terms of preexisting conditions and the ability to renew their policies and other forms of disclosure so that they know, going in, but also are protected during the course of their policy as well. I feel that really there is a lot of national work that has been done on that, and we really have not adopted it too much. We have just basically concurred in it.

Probably the toughest area I think—and I do not yet know how we are going to do it—is if we have a multitude of companies offering qualifying policies, how are the systems of those companies going to inner relate to the State Government administrative system for Medicaid? How are we going to make sure that when an insured starts drawing down their private benefits, that the benefits they are drawing down are only those benefits that are eligible to be counted against this insurance amount are counted and are basically tallied on the Medicaid for the purpose of the Medicaid program? And then during the course of their stay in private care, how do we make sure that the continuing relationship—what kind of reporting requirements should the private sector have to make sure that they get the information to the Government but not to be overly burdensome.

So there is a lot of kinds of nuts-and-bolts administrative issues that we have not yet solved. That is our next goal in the next few months. But when you cut it all away, I think it is kind of a situation in a small way like we were in when Franklin Roosevelt was trying to get us out of the Depression. He said, "Well, let's try this.

And if that doesn't work, let's learn what we can and then let's try something else."

I think we are at the limits of our theoretical knowledge and we can only learn more by actually getting into it. And again, that is why, to come back to the waiver, not to harp on that too much, but only by doing these programs are we now going to advance our learning significantly.

Senator COATS. We do have about 10 minutes before we want to bring our next panel on, and I would like to open this up for audience participation. So if any of you have questions that you would like to ask me or any of the panelists, we would be happy to entertain those at this time. The only thing we ask is that you stand and speak loudly enough so that we can hear the question. Any questions for the panelists? You might even make the evening news if you ask a good enough question.

AUDIENCE MEMBER. I do have a question. I was just wondering, you take Indianapolis, for instance, where you have Wishard Hospital that make a lot of business. We have a lot of medical costs indexing, probably gone up higher than any other indexing has ever gone up in the past. What is going to happen with some of these hospitals that are claiming they are losing a lot of money, and are they going to be able to stay in business? Are they going to be able to exist? Not only Wishard, but I am sure other hospitals all over the country are experiencing the same thing.

Senator COATS. Ben, do you want to address that one?

Mr. LYTLE. Yes. I think the natural outcome of a lot of those situations, both in Indiana and it has already occurred in other parts of the country, is you are going to see some mergers of hospitals. We have already had one occur here in Indianapolis with Community Hospital and University Heights Hospital in Greenwood, and that is not necessarily a bad situation. What is devastating is when you lose a hospital and nobody picks up the service area. Then you have a really terrible situation, and that has occurred in a few cities in the East. But more often than not, there has been a merger or an acquisition of a facility by a larger, healthier facility that continues to operate it. And that is what I hope will occur here in Indiana, and so far that is what has occurred.

Mr. MEINERS. If I could just put a little twist on the question, bring it back to this issue, I think one of the things we have to worry about in health care policies is having enough resources to pay for care. I do not think we really have yet understood in this country that it is truly a blessing to have the life span that we have. But with that blessing goes the reality that we are going to have some years of our life where we are going to need long-term care very possibly, and we need to start planning individually as well as the Government.

The Government cannot do it all, and I think that is at the heart of what we are trying to do here. We are trying to provide the kind of incentives and in a program so that people can be encouraged to put aside as much for themselves so that when the Government does step in, it can step in in a way that compliments that, not tries to do the whole job. Because when it does try to do the whole job, we have found that there are not enough resources to go around. And when that happens, we tend to cut here and there and we are not very happy with the outcome of that, and that is sort of at the heart of this program. If we do that, we will have the resources to pay for our needs as we age and we will have guidance as to how to do that in a way that we kind of feel good about it. Right now that is not the case.

Senator COATS. Anyone else? Yes, sir.

AUDIENCE MEMBER. Direct a question to Mark Meiners. Yesterday's Wall Street Journal pointed out what the media often do not tell us: That private pension plans pay out more dollars than does Social Security. Now, looking toward the financing of long-term care, would you give us your up-to-date judgment based on the research you have already done as to what share should we look for the national Government to pay, State, employers and employee/ other people independently employed, in other words the patient himself?

Mr. MEINERS. That is an excellent question. And I had not seen the article, but I think it allows me to point out something that I think we do not quite reflect on, and that is when it comes to long-term care, at least the formal part of the bill, about half of it is paid by the Government and half of it is paid by the individual. And frankly, I think that that is not a bad mix or at least it is a realistic mix. The problem with that mix today is that the half paid by the individual is pretty much paid out-of-pocket, meaning there is none of this insurance around or at least it is only beginning to be around and it is not widely held and for a variety of reasons we are trying to address in this program.

The problem with that, then, is that for those who need long-term care, it is truly catastrophic and they end up spending their resources and ending up on Medicaid. So what we have is that some middle class people who could have, perhaps planned had they had this kind of program, do not plan and end up on the public system, which places extra burden on that system.

So in answer to the question, I think a 50/50 mix is not bad but that we can do a better job in thinking about those 50/50 proportions.

Senator HUNT. Mark, there is a tendency—maybe you could update me on it or Ben could—where employers are offering long-term care as a component in the group health policies of their work force. And ironically from what I read, a year or so ago the average age of people taking advantage of that was 40 or in the low 40's or something like that. Is that trend continuing?

Mr. MEINERS. I think that there is a growing recognition of the need to get involved in planning for your retirement in all respects at an earlier age, and this is one that I think is only beginning to be recognized as an important part of what retirement is. Really when you think in addition to pensions and Social Security, what we are really saying is that there is a very special need for your own resources out there, and that is specifically for long-term care. And long-term care to a large extent is something that pension dollars can go for, but also I think what I am really saying is that there need to be more resources out there. So planning this in a way that gets employers to offer it at least as an option and perhaps down the road really starting to think in terms of it being offered with pre-tax dollars, which is a little bit complicated thing.

But right now most of your health benefits are paid pre-tax. Long-term care is not one of those. Little things like that can provide the kinds of incentives to get employers and consumers at a younger age to get involved in setting aside the resources for this particular problem.

I think then having done that, we could have a Medicaid-type system out there serving as the back-up, as we are proposing in this program, but have it be out there in a way that it really is available to people who really had no chance to plan for this problem, just did not have the resources. Many of us can. We just need the incentives and the opportunity to do so.

Senator COATS. Ben, what are we talking about in terms of long-term care policies, in terms of cost and coverage? What are the options that are available, and what is it going to cost someone at different ages? Are they buying a term policy? Are they buying——

Mr. LYTLE. It is somewhat akin almost to a life policy in a lot of ways, but I think as Mark would tell you, we are a long way, I think, from coming up with a price structure that is something that the general public can count on and will adopt. And of course price is tied to benefits, and that is why this particular effort is so important, because it is the first time there has ever been an attempt to coordinate between the public and private payers, and it is just the opposite.

One of the things to me that is so attractive about this approach is it is just the opposite of what has occurred in the basic health care system where everybody shifts cost to each other. The Federal Government tries to shift to the States and to private and private tries to shift to the Government. And in this case there is a coordination of costs, and I think that is what makes it so attractive. I do not think we are even close yet to coming up with what you might call a universal price or price that you could say, "Well, this is about what that ought to cost." I do not think we are there yet.

Senator COATS. How far away are we?

Mr. MEINERS. I think that we are gaining rapidly in terms of our knowledge, certainly such that the private market has gone from virtually nonexistent to having millions of policies in the past couple of years, which suggests several things: That the information that they have at their disposal is sufficient to make them confident going forward in the market and the products can be priced such that consumers are willing to buy that.

I think the kind of thing we are talking about adds the extra edge that we need, and that is that we really want to see these products become available to a broad spectrum of middle income people. And to do that, we want to be able to make sure that people can feel comfortable that they have some sort of a lifetime commitment that they can protect some of their resources. Currently, if people only could afford, for example, a 1-year insurance policy, they may well think that is not good enough because the average risk is around 1 year and so OK, I won't bother. With this kind of a commitment there is an additional benefit, and that is in the State of Indiana when the program goes through, that is that roughly 1 year's worth of assets would be protected. That is, if the nursing home or if the long-term care policy for nursing home, and home and community care benefits paid out roughly the equivalent of 1 year's worth of benefits, the individual would then be able if they had to go on Medicaid after that to have Medicaid access without having to further spend their resources. They would protect some of their resources. That is a significant add-on benefit that does not in our calculations cost the State anything. It is significant to the consumer, and it encourages a person who might well have ended up on Medicaid to now buy a private insurance policy and very likely stand a chance of not needing to ever come onto the Medicaid system. It is kind of a win/win situation.

With that in place as a motivation for the insurers to market and the State to get involved, we will have a basis for having them, as I mentioned, insured. Otherwise it would be proprietary information with the State, so that some of the concerns about pricing these policies can be resolved as we go along in a much more informed fashion. So in some sense what we are suggesting is we have a link with Medicaid that has a motivation providing with a structure—providing us the basis for establishing a structure within which we can do a better job of understanding long-term care needs and how our population is likely to change over time in terms of those long-term needs.

Senator COATS. I want to thank our panelists Mr. Lytle, Mark Meiners, and Senator Hunt for your presentations this morning. It was very helpful. I appreciate you taking the time to be here, and we look forward to working with you in the coming years on these problems. [Applause.]

Our second topic this morning is the question of home health care options. We specifically want to look at Indiana's Choice Program, but we also want to talk about other options that are available or might be available or that we ought to be looking at. And so we have assembled a panel of people designed to give us some input and some answers as to those questions.

That panel consists of Mike Sullivan, who is director of the Indiana Association for Home Health Agencies; State Representative John Thomas from Brazil, IN, who has been instrumental in working in home health care options; Eleanor Kinney, the director for the Center for Law and Health, Indiana University School of Law; Jeff Richardson, who is the acting commissioner of the Department of Human Services for the State of Indiana; and Scott Severns, attorney from Severns and Lewis, policy analyst for the group called United Senior Action, and a specialist in law and questions which affect the elderly. So if those panelists will come forward, we will hear a brief summary presentation by each of them and then open it up again for questions. And I want to thank the panelists for your participation this morning.

Mike, I believe we will start with you and then just go right on down the line.

STATEMENTS OF MIKE SULLIVAN, DIRECTOR, INDIANA ASSOCIATION OF HOME HEALTH AGENCIES; HON. JOHN THOMAS, INDIANA STATE REPRESENTATIVE, BRAZIL, IN; ELEANOR KINNEY, ASSOCIATE PROFESSOR OF LAW AND DIRECTOR, CENTER FOR LAW AND HEALTH, INDIANA UNIVERSITY SCHOOL OF LAW, INDIANAPOLIS, IN; JEFF RICHARDSON, ACTING COMMISSIONER, DEPARTMENT OF HUMAN SERVICES, STATE OF INDIANA; AND SCOTT SEVERNS, ATTORNEY, SEVERNS AND LEWIS, POLICY ANALYST, UNITED SENIOR ACTION

Mr. SULLIVAN. Thank you, Senator. It is really a pleasure to be here today to discuss home health. When I talked to Dane Starbuck, he requested that I give the overall perspective of home health in the State. As the director of the Indiana Association of Home Health Agencies, we are responsible for about 120 of the 140 home health agencies in the State, representing them before the different bodies of legislation and regulation and acting on their behalf, so we are really pleased to be here today.

Home health is definitely a mystery that has arrived. Five or 6 years ago you mentioned home health care, and people would kind of look at you like, "What are you talking about? Are you talking about home repair? What do you mean home health care?" It is definitely an industry that is growing and will continue to grow.

I'd like to give some brief Indiana statistics to give everybody an idea of where home health care is in the State of Indiana. The State Board of Health—and I will include this in the materials we give to the Senator—puts together an annual activity report each year. For the calendar year 1987, 100 of the 140 licensed home health agencies of the State of Indiana reported. They reported that they gave 553,322 intermittent visits to individuals and also rendered 747,264 hours of extended care services to 28,000 patients. More than one-third of the patients received services for heart disease, cancer or stroke, and this is consistent with State and national data. Upon completing the program of home care, 62 percent of the people were discharged to themselves or to their family. What this meant was upon completing their regimen of home care, they were well enough to take care of themselves and be on their own.

Sixty percent of the home care visits in Indiana were reimbursed by Medicare. Insurance covered 11 percent; out-of-pocket payment covered 11 percent; and Medicaid reimbursed 8 percent. All 92 counties in the State are at least minimally served by a home health agency. This is a relatively new statistic because as recently as 1976, only 35 counties were covered, but now today all 92 are covered. The total expenditures as reported by the State Board of Health activity report was $30 million; however, the figure is much higher than that because that only includes direct home health services rendered by licensed home health agencies. Currently there are some unlicensed agencies in the State, a problem which will soon be taken care of since Indiana did pass a mandatory licensure bill recently; and also, home health agencies have expanded their scope where they are now involved in durable medical equipment, pharmacy and a lot of therapies that are not counted in that dollar rendering. So even though the report says it is $30 million, it is actually much higher than that when you look at the broader scope of home health care.

I'd like to address the main payers and the restrictions of those payers for home health care, and then we will get into why Indiana has done some of the novel things it has. Medicare is by far and away the largest payer for home health care. Again, it said about 60 percent of the visits in Indiana. However, one of the things that must be emphasized is Medicare is only an acute care benefit. It does not incorporate a long-term care at all.

The qualifiers to be medically eligible under Medicare, obviously you must be eligible for Medicare benefits to begin with, but there are three other things that must be met. One is called medical necessity, which means that the care rendered must make you better; the care rendered must be part-time or intermittent; and finally, the patient must be home bound. The Health Care Financing Administration recently issued a document on how an agency should go about determining this eligibility, and you can see from the flow chart that it starts out on tier one and then goes to tier two and it is an extremely complicated process. This will also be included for the Senator.

One other thing about Medicare is that the benefits were expanded under the Catastrophic Act, which was recently repealed. Congressman Pete Stark has recently introduced the Medicare Benefit and Improvement Act of 1990, and this restores some of the long-term care and/or home health benefits that were incorporated in the original Medicare Catastrophic Act. These include mammography screening, expanding the definition of home care services to say that the definition of intermittent means that a patient may receive daily care for 38 straight days; and it also defines the definition of daily as 7 days a week. Believe it or not, it has been an ongoing fight for years with the health care financing administration as to what the definition of daily is. I think it is rather logical, but they said it was 5 days a week. And we said, "Well, if people are ill, they do not miraculously get better on the weekend." So this piece of legislation would take care of that. It also includes a respite care provision of up to 80 hours per calendar year and removes the lifetime limitation of 210 days for the hospice benefit.

And then last about Medicare—this is one thing I would really like to direct toward the Senator, particularly on the advent of Gramm/Rudman cuts—home care under Medicare is reimbursed on a cost basis. So when the Gramm/Rudman cuts delete 2 percent from a home health agency, they are in fact only getting 98 cents for every dollar rendered. Unlike hospitals or nursing homes that are reimbursed differently, home health agencies are purely on a cost basis, and so that really impacts them dramatically and drastically.

Medicaid does recognize components of long-term care. Indiana Medicaid Division says that it will recognize 39½ hours of care per week for long-term care with some notable exceptions, such as ventilator dependent children and the like. The biggest problem with Medicaid is the stringent financial eligibility requirements in regards to income and assets; and also, Medicaid is still predominantly a nursing home benefit as exhibited by the fiscal year 1989 statistics that showed Medicaid spent $420 million on nursing home care and only $3 million in home health care in fiscal year 1989. Also, that $420 million figure does not include the $124 million spent on the ICFMR, which is the Intermediate Care Facilities for the Mentally Retarded. So you can see Medicaid is expending over $575 million on institutionalization versus $3 million for home health care.

Insurance is improving dramatically. Insurance originally followed the Medicare guidelines, but now as we have seen, the insurance industry is beginning to really look into the long-term care aspect of health care also.

The growth of home health and the necessity of home health is based on five factors. It originally started when the diagnostic related group aspect was instituted for hospitals 6 or 7 years ago. This is when Medicare stopped reimbursing hospitals on a per-day basis and started reimbursing them on a per—on a basis of how much the patient was in the hospital. Regardless if you were in there for 2 days or 5 days, you got "X" amount of dollars.

Technology has also increased the aspect of home health care. Ventilators, IV nutrition and IV antibiotic therapy that as recently as 5 or 10 years ago were done only in intensive care units are now being done in the home, effectively and efficiently. The aging population, which everybody is familiar with, is going to have a dramatic impact on home care. The cost and the preference are the last two.

The future really holds some interesting things. You have already heard about the governor's long-term care insurance project. This holds a fantastic private/public aspect for the State of Indiana for long-term care insurance. The Choice Program, which representative John Thomas introduced and I am sure that he and Scott Severns and Jeff Richardson will expand upon, that has been a program that has really put Indiana in the forefront as a gap filling program. As we mentioned Medicare, Medicaid insurance often times have dramatic restrictions on them. Choice is a program as a gap filler. It is the money that is last spent. We have found that it has been a fantastic program in rendering home care services to individuals in Indiana.

Also, the Choice Program in conjunction with the Department of Human Services and the Department of Public Welfare has recently submitted a Medicaid waiver to HCFA. This is a waiver, and maybe Jeff will go into that. I am not sure what he has for his presentation, but it will allow Medicaid to reimburse other services. There it is, all right. [Laughter.]

That was fantastic work on their part to get that in. That was submitted to Health Care Financing Administration on January 3, and it allows non Medicaid aspects to be reimbursed by Medicaid under a particular circumstance. Indiana currently has a Medicaid waiver program that is not very effective. The components of that program that make it ineffective have been eliminated and expanded in this new waiver, so we are really pleased to see that.

And last, we are looking forward to the Federal action on long-term care. I am sure that the Senator is well aware of the Pepper Commission which will probably have its first report I believe in March of 1990. And we would also like to investigate what is Congress's attitude in light of the catastrophic impact, how the elimination of that benefit is going to impact what Congress is going to do in regards to long-term care. And then also and last is—it is going to be very interesting to see over the next several years as the Defense Department winds down its budget request due to the disarmament in Eastern Europe, will those funds be available for long-term care and health care. So we are very pleased to be here. Thank you, Senator.

[The prepared statement of Mr. Sullivan follows:]

MICHAEL SULLIVAN
Executive Director

PREPARED STATEMENT OF MICHAEL SULLIVAN

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January 17, 1990

I. Home Health is an industry that has arrived.

II. Indiana Statistics from the Annual Activity Report for Home Health Agencies (Calander Year 1987) as compiled by the Indiana State Board of Health: (ENCLOSURE I)

- -100 of the 140 licensed agencies reported.
- -there were 553,322 intermittent care visits and 747,264 hours of extended care service to a total unduplicated census of 27,484 patients reported.
- -more than one-third of Indiana's home health patients received services for heart disease, cancer, or stroke; this is consistent with state and national disability data.
- -upon completing their program of care, 62% of the patients were discharged to self or family (no other care was needed).
- -60% of the visits were reimbursed by Medicare; insurance covered 11%; private pay accounted for 11%; and Medicaid reimbursed 8%.
- -All 92 counties are served at least minimally by a home health agency.
- -total reported expenditures were $30 million.

III. Payment and Restrictions
A. Medicare
- -acute care benefit
- -qualifiers include medical necessity, parttime or intermittent, and homebound (ENCLOSURE II)
- -Medicare Benefit Improvements Act of 1990 (ENCLOSURE III)
- -Gramm/Rudman cuts hurt home heatlh since it is a cost-based program under Medicare.

B. Medicaid
- -recognizes some aspects of long term care in the home
- -stringent financial eligibility guidelines
- -still predominately a nursing home benefit in regards to long term care as approximately $420 million was spent in FY 89 on SNF/ICF care versus $3 for home care. (The $420 million figure does not include $124 million spent on ICF/MR.)

C. Insurance
- -improving dramatically, but often follows Medicare

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IV. Growth and Necessity
- -DRGs
- -technology (ventilators, chemotherapy, nutrition, anitbiotic therapy now done in the home)
- -aging population
- -cost
- -preference

V. Future
- -Governor's Long Term Care Insurance Project
- -CHOICE (ENCLOSURE IV)
- -Newly submitted Medicaid Waiver to HCFA
- -Federal action on long term care
  - Pepper Commission
  - Catastrophic impact
  - Defense reductions

Determination of Parttime or Intermittent Skilled Nursing and Home Health Aide

Tier I - Qualifying Decision

A. Patient qualifies based on the need for intermittent skilled nursing only (i.e., needs no PT, ST, or continued OT)

Make a decision on intermittent based on intermittent criteria in effect prior to Duggan, i.e.

- daily (5, 6 or 7 days) for a predictable and finite period of time.
- Must be a medically predictable recurring need for skilled nursing.

1. If SN does not meet intermittent criteria no payment can be made for any home health services.

2. If SN meets intermittent criteria and no aide visits are present review and adjudicate the claim as you would normally.

3. If SN meets intermittent criteria and aide visits are present go to Tier II to determine if services are part-time or intermittent.

B. Patient qualifies based on a need for PT, ST or a continued need for OT.

1. If SN and/or aide visits are present go to Tier II to determine if the visits are parttime or intermittent based on the new policy.

2. If no SN or aide visits are present, adjudicate claim as you would normally.

Tier II - Parttime or Intermittent Decision

A. Add total SN and aide visits on the bill.

B. Divide total SN and aide visits by days in the billing period.

1. If result is 2 visits or less per day review and adjudicate bill as you would normally.

2. If result exceeds 2 visits per day request from the HHA actual hours the SN and aide separately spent in the home on each visit date billed and where hours exceed 8 hours per day or are 35 hours or more per week the time each SN and aide visit began. Go to C. below.

C. Apply criteria in HHM 206.7 A and B.

Criteria in either A or B must be met.

1. If criteria is met continue review and adjudicate bill as you would normally.

2. If criteria is not met, the visit(s) beginning on or after the first hours of service per day and/or per week which exceeds parttime and intermittent are denied. If no visit begins on or after these hours payment is made for the visits in question (see example).

Examples:

Services rendered are medically necessary.

- SN and aide visits 7 days per week beginning on Monday;
- SN visits from 8 a.m. - 10 a.m. daily; and
- Aide visits from 11 a.m. - 2 p.m. daily.

Since there is no visit which occurs on/or after the 35th hour each week, all visits are payable assuming all other criteria for home health coverage are met.

Examples:

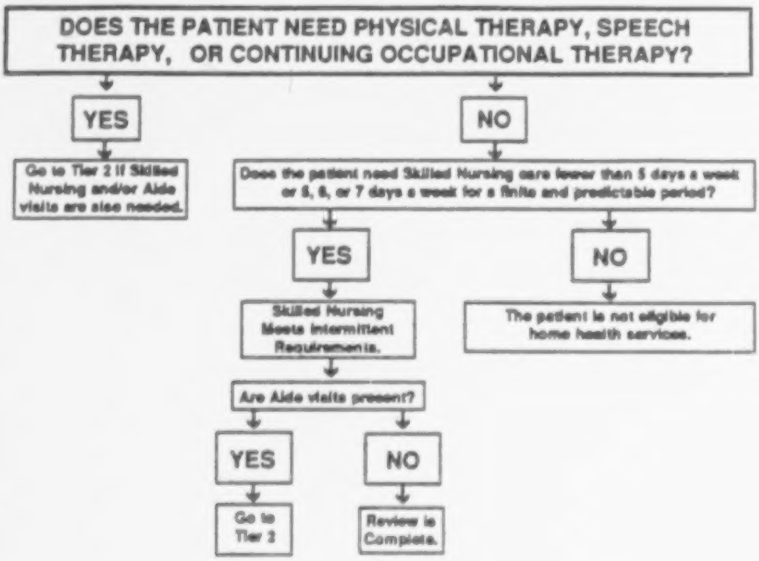
Services rendered are medically necessary for a finite and predictable period.

- SN and aide visits 7 days per week with the week beginning on Sunday;
- SN visits from 8 a.m. - 11 a.m. daily; and
- Aide visits from 10 a.m. - 5 p.m..

All visits are payable assuming all other criteria for home health coverage are met.

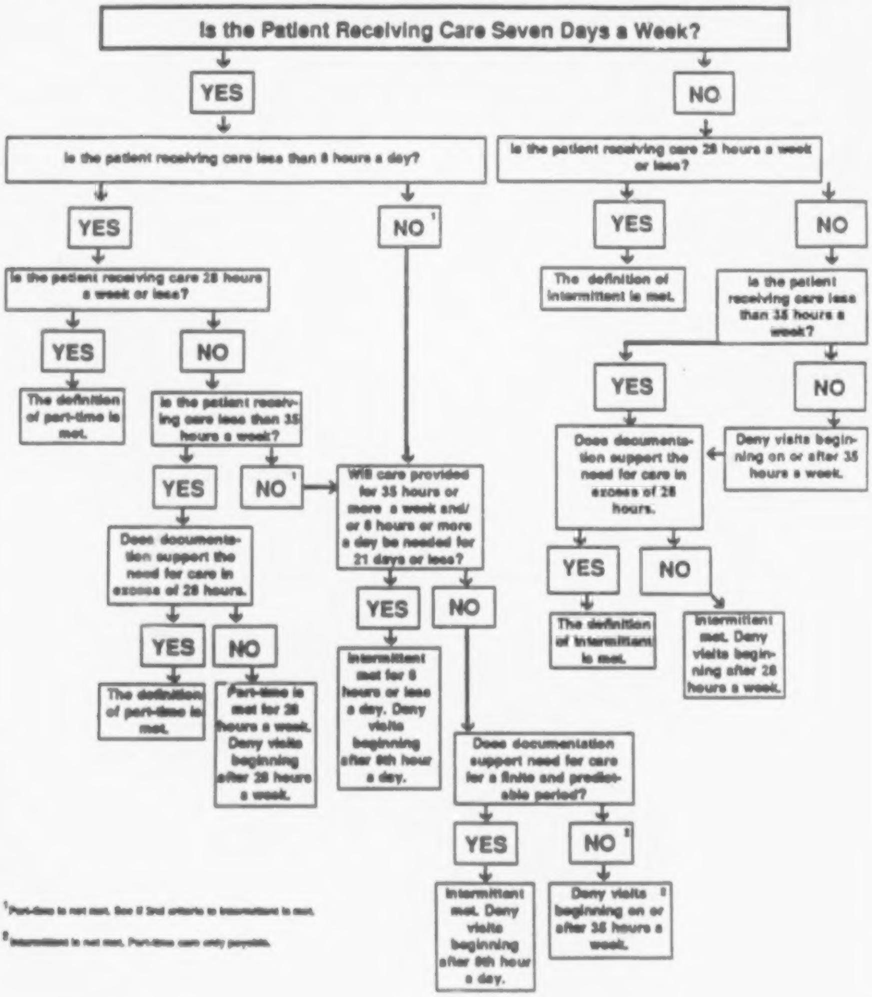
DESK AID - For Guidance In Determining if Skilled Nursing and/or Aide Services are Part-time or Intermittent

TIER 1- On what basis is the patient eligible for home health services?


DOES THE PATIENT NEED PHYSICAL THERAPY, SPEECH THERAPY, OR CONTINUING OCCUPATIONAL THERAPY?
YES
NO
Go to Tier 2 if Skilled Nursing and/or Aide visits are also needed.
Does the patient need Skilled Nursing care fewer than 5 days a week or 5, 6, or 7 days a week for a finite and predictable period?
YES
NO
Skilled Nursing Meets Intermittent Requirements.
The patient is not eligible for home health services.
Are Aide visits present?
YES
NO
Go to Tier 2
Review is Complete.

DESK AID - For Guidance In Determining if Skilled Nursing and/or Aide Services are Part-time or Intermittent

TIER 2- Are Combined Skilled Nursing and Home Health Aide Visits Part-Time or Intermittent?


Is the Patient Receiving Care Seven Days a Week?
YES
NO
Is the patient receiving care less than 8 hours a day?
Is the patient receiving care 28 hours a week or less?
YES
NO 1
YES
NO
Is the patient receiving care 28 hours a week or less?
The definition of intermittent is met.
Is the patient receiving care less than 35 hours a week?
YES
NO
YES
NO
The definition of part-time is met.
Is the patient receiving care less than 35 hours a week?
Does documentation support the need for care in excess of 28 hours.
Deny visits beginning on or after 35 hours a week.
YES
NO 1
Will care provided for 35 hours or more a week and/ or 8 hours or more a day be needed for 21 days or less?
YES
NO
Does documentation support the need for care in excess of 28 hours.
The definition of intermittent is met.
Intermittent met. Deny visits beginning after 28 hours a week.
YES
NO
YES
NO
The definition of part-time is met.
Part-time is met for 28 hours a week. Deny visits beginning after 28 hours a week.
Intermittent met for 8 hours or less a day. Deny visits beginning after 8th hour a day.
Does documentation support need for care for a finite and predictable period?
YES
NO 2
Intermittent met. Deny visits beginning after 8th hour a day.
Deny visits beginning on or after 35 hours a week. 2

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[1] Part-time is not met. See if 2nd criteria to Intermittent is met.

[2] Intermittent is not met. Part-time care only payable.

Senator COATS. Thanks very much, Mike.

Representative John Thomas is very instrumental in the Choice Program. John, we appreciate the time you are taking. I know your schedule is very busy too and we are interrupting the legislative work that is under way right now, but thanks for coming over and talking to us about an important program.

Mr. THOMAS. Thank you, Senator Coats. And let me on behalf of not only myself but the Members of the Legislature and those persons interested in home health care thank you for putting this on your agenda today. And yes, the committee meeting for age and aging of which I am a member is to meet in about a minute and a half at the State House, but I told them I would be a little bit late. I very much appreciate the invitation, and as I look about, I see a lot of people here that have been instrumental in supporting this program.

I also have with me some high school seniors, and if I might just take just a moment to introduce and ask them to stand up, not introduce them by name, six seniors from Northfield High School that I brought along with me this morning. Would you stand up to see there are some folks here in addition to—thank you. [Applause.]

Senator COATS. Let me tell them, your interest in long-term care will come quicker than you think. [Laughter.]

Mr. THOMAS. Thank you, Senator. Back in 1986, an official committee was appointed by the Indiana Legislature to study the home care possibilities and make recommendations back. That committee did meet, and then in 1987, I had the privilege of authoring that legislation which the committee recommended. And so effective as of September 1, 1987, the Choice Program, or home care program, was in effect. We started out with only $1½ million appropriation, and at that time I am sure there are some people in the State in high places that were not all that enthusiastic about the program, had some doubts about the program. But it has progressed I think very well, and we are having money problems in the State.

Now, let me tell you for just a moment, Senator, what the program is. It is for persons who are at least 60 years of age or disabled persons of any age who are at imminent risk of going into a long-term care facility, such as a nursing home. And for those persons that are at risk, that could be served in their own home setting at a cost not to exceed what it would cost in the nursing home, for example. They are eligible to receive that program. However, we started out with only four counties in Indiana that the program was being used in. We have now expanded to nine counties. We are hoping with some additional funding this session to go to 20 counties, and it depends upon the amount of funds we get as to the extent even in those 20 counties that the program may be used.

I want to compliment Jeff Richardson, as the commissioner of the Department of Human Services under whom that program is lodged, and also specifically the director of that program, Geneva Shed, who is here; and both of those persons in my opinion are doing an excellent job to bring that program to us consistent with the amount of money that we make available to them. And that gets into a little bit of what Mr. Sullivan said.

The Medicaid money that comes to us is limited only to nursing homes and other long-term care facilities, and it would be my opinion that this $575 million or so that he mentioned that we are using in that program in Indiana could be more wisely used in some cases in having it made available for the home care program, because the report that the commissioner has given to us shows that even with the expenditures that we are making and giving the people the dignity of staying in their own homes for a longer period of time in some cases, we are also saving money. And the report that he recently gave to us shows for 1989 that we saved, I believe, over $800,000 in the use of that program. And if we expand it as we hope to in 1990-1991, we will save in the millions of dollars. That is a savings in addition to bringing that program to the people.

Now, one thing that has not been implemented to the extent in the past that we feel, Senator, should be done—and the present administration and the department is doing that by the rules that are in the process of being adopted—is the ability-to-pay feature. The law says those persons that I have indicated are eligible and those persons who are able to pay should pay proportionately to their ability for those services in their own home. And I think with the implementation of the rules that are being adopted, that that will bring more money into the program and will extend it, to the extent that feature of it is used, to even more areas of this State and to more people in those areas.

This is a program that the senior citizens of this State and the disabled of this State are very much interested in seeing expanded, and I would like to pledge my support and my cooperation with you and your office in doing anything that the Federal Government can do to make those funds available for the home care program, especially since it is a money saving feature both to the person himself/herself, to the State and to the Federal Government.

[The prepared statement of Mr. Thomas follows:]

PREPARED STATEMENT OF JOHN THOMAS

INTRODUCTION AND SYNOPSIS

In 1987, the Indiana General Assembly passed P.L. 42 (I.C.4-28-6) and created CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled Program).

When CHOICE was passed, expectations were high among elderly and disabled Hoosiers that improved and affordable home care would soon be a reality. Expectations were equally high that the fear of impoverishment and lifelong involuntary institutional confinement would soon be a thing of the past.

Today, these expectations remain unfulfilled.

Three years since the passage of the CHOICE law, affordable and accessible home care remains but a bitter illusion for most Hoosier families. At the present time, CHOICE is operating in only nine counties, and in those counties, the program, since September 1989, has had an "informal moratorium" on the intake of new clients. As a result, if an Indiana citizen is eligible and needs home care in order to avoid institutionalization, that care is not likely to come through the CHOICE program, even in the nine counties where CHOICE services are offered.

The CHOICE "crisis", created when the program was underfunded and at the same overexpanded, is endemic to publicly funded home care programs throughout the state. Recent cuts in federal funds for non-CHOICE home and community care programs, combined with the lack of state action to address the federal reductions, are forcing severe program and staff reductions throughout Indiana.

But this crisis can be solved.

The Indiana Home Care Task Force[1] recently estimated that supplemental appropriations of $20 million for CHOICE and $5 million for statewide home and community care case management programs[2] are needed for the 1990-91 budget biennium. These funding levels would allow the state to 1) lift the current moratorium on new clients in the nine counties; 2) expand CHOICE from 9 to 20 counties as the Administration pledged to do in June 1989[3]; 3) stop the staff and program lacerations of home care programs in non-CHOICE counties; and 4) place CHOICE back on a trajectory of statewide implementation before the mid-1990s.

These appropriation decisions are the primary challenge facing home care in Indiana today. These decisions can only be made by you and your colleagues in the General Assembly. In the bipartisan spirit with which the 1987 model home care act was passed, the citizens of Indiana are hoping you will act in 1990 to reaffirm the state's commitment to home care. Where implemented, CHOICE has proven to be a much needed and appreciated program[4]. However, the promises and cost-effectiveness of home care, as an alternative to more expensive institutional care, can be achieved only if the program is properly funded.

In 1990, we hope and pray that you will act to properly fund CHOICE.

II. THE CURRENT STATUS OF THE CHOICE PROGRAM AND HOME CARE IN INDIANA

CHOICE is located and operating in Tippecanoe, Knox, Daviess, Allen, Orange, Washington, Lawrence, Crawford and Martin counties. The expansion of CHOICE into eleven additional counties, announced by the Administration in June 1989, has not occurred, primarily because of the funding crisis, and secondarily, because of a number of administrative issues. The problems plaguing the program and its expansion have been well documented in an October 23, 1989 Task Force study, which was distributed to the legislature.[5]

Presently, the Task Force, the Area Agencies on Aging (AAAs) and other interested parties are working with the Indiana Department of Human Services (IDHS) to develop improved guidelines and procedures for CHOICE. (IDHS administers home care on a statewide basis.) In fact, an IDHS draft document and Task Force analysis were examined in a productive December 18, 1989 public hearing in Indianapolis[6]. At the meeting, the IDHS announced a timeline of July 1, 1990 for adopting proposed operational changes as formal rules, a timeline which the Task Force feels is reasonable.

The Task Force is cautiously optimistic that this process will lead to a fairer and more effective client cost-share (sliding fee) payment system based only on the client's actual income. The Task Force also hopes methods for determining client eligibility, which do not arbitrarily eliminate nor unfairly reduce care for persons who are at-risk of institutionalization, are developed from this process.

However, the fundamental factor driving the home care crisis remains underfunding. The lack of funds is the primary reason for the informal moratorium placed on new client intakes since September 1989[7]. The moratorium is distorting client intake patterns, making it difficult to determine what the natural limits should be for clients entering the program. The moratorium is having two pernicious effects: 1) persons who need CHOICE are now being referred to the program in fewer numbers by community social service agencies, and 2) the task of projecting budget needs is becoming more difficult.[8] As a result, people needing CHOICE services are now being placed on waiting lists or are simply staying away from the program.

As a result of the moratorium, the numbers of individuals on waiting lists for CHOICE services are at high levels, despite only a remote possibility of receiving services (see Appendix B). This is a testament to the critical need for home care in the counties being served and in Indiana as a whole. A cruel irony of the CHOICE program is the number of people on waiting lists who have been terminated due to death or placement in nursing homes.

Finally, people needing CHOICE services in the future will also be victims of budgetary underfunding.

Given the pervasiveness of the moratorium and underfunding impacts on local (AAAs), it is amazing that they are able to conduct a quality home care program. For clients who were on CHOICE before the moratorium began and for the few who have come into the program since, it remains a program of outstanding quality. Organizations which are members of the Task Force, such as AARP, the Indiana State Council of Senior Citizens, Citizens Action Coalition, Indiana Retired Teachers Association and the Council of Volunteers and Organizations for the Handicapped all report overwhelming praise for the program from their members who are CHOICE clients[9].

In counties without the CHOICE program, the decline in funds for case management and continuing pre-CHOICE home and community care programs is putting more Hoosiers at risk of institutionalization. In the metropolitan Indianapolis area alone it is estimated that funding cuts will lead to a loss of 40% of all case managers[10]. Case managers are the core of any successful home care program since they perform client assessments, put together care plans, broker for services from providers and intervene for clients who receive unsatisfactory services. If these skilled people are lost because of the state's failure to make-up cuts in federal funding, it will be very difficult to expand CHOICE into the non-CHOICE counties. The effectiveness of CHOICE in counties such as Tippecanoe has been based on a core of skilled and experienced case managers being in place prior to the establishment of CHOICE. Wise public policy means taking fiscal action to retain and upgrade case management across the state.

III. TASK FORCE BUDGET PROJECTIONS

The Indiana Home Care Task Force has examined the question of how much money is needed in supplemental appropriations for the 1990-91 biennium for CHOICE and home care case management across the state. (See Appendix C.) The Task Force has unanimously endorsed[11] appropriation levels of:

- $20 million for the CHOICE program
- $ 5 million for home care case management in non-CHOICE counties (statewide)

The Task Force believes these funding levels are needed to put Indiana on a timely trajectory for statewide implementation of CHOICE while meeting the program's current funding crisis.

The Task Force urges the bipartisan leadership of the Indiana General Assembly to make a commitment to implement CHOICE statewide by 1994 and to sustain statewide case management programs.

CHOICE was enacted into law as a statewide program beginning in September 1987. The Task Force believes the public has been more than patient with state policy makers relative to the funding of CHOICE. Each day, week, month and year which passes adds thousands of Hoosiers to the history of suffering because the promises of the 1987 act remain unfulfilled.

The Indiana Home Care Task Force is asking the 1990 General Assembly to fulfill the promise of the law. Let elderly and disabled Hoosiers have lives of security and dignity.

APPENDIX B

Area Agencies on Aging

Area 3: Allen County
Area 4: Tippecanoe,(original county) White, Carroll, Clinton, Montgomery, Fountain, Warren, Benton Counties (additional counties announced June 1989)
Area 13a: Knox, Daviess, Martin, (original counties) Pike, Dubois Counties (additional counties announced June 1989)
Area 15: Orange, Lawrence, Crawford, Washington Counties

TABLE I

CLIENT LEVELS

(Information from Area Agencies on Aging)

Area	Sept. 1989	Nov. 1989	Jan. 1990
3	240	247	248 [a]
4	307	270	243 [b] [c]
13a	560	465	414 [a] [d]
15	162	148	118 [e]
	1269	1130	1023

a. End of December, 1989
b. Mid-December, 1989
c. Clients in Tippecanoe County.
d. Clients in Knox, Daviess and Martin Counties.
e. January 5, 1989

TABLE II

WAITING LISTS[a]

(Information from Area Agencies on Aging)

Area	Jan. 1990
3	165 [b]
4	279 [c] [d]
13a	205 [b] [e]
15	107 [f]
	756

a. Because of the informal moratorium on the program and public knowledge that very few new clients are being added, agency, hospital and family referrals to the CHOICE program have slowed down tremendously since September 1989.
b. End of December 1989
c. Mid-December 1989
d. Waiting list includes individuals from all eight counties in Area 4.
e. Waiting list includes individuals from all five counties in Area 13a.
f. January 5, 1990

TABLE III

APPROPRIATIONS FOR CHOICE PROGRAM

Fiscal Year	Appropriation
1988	$ 1.5 million
1989	5.0 million
1990	8.25 million
1991	12.25 million

TABLE IV

LONG TERM CARE MEDICAID EXPENDITURES[a]

Fiscal Year	Expenditure	Increase over prior year
1988	$396 million	+ 3%
1989	420 million	+ 6%
1990	459 million [b]	+ 9%
1991	495 million [b]	+ 8%

a. 1988 and 1989 figures from Indiana Dept. of Public Welfare Annual Reports. Expenditures for Skilled Nursing Facilities and Intermediate Care Facilities. Expenditures do not include institutional care for ICF/Mentally Retarded, even though the mentally retarded can be served by CHOICE. Current average statewide Medicaid costs for an SNF are $1957 per month, and average costs for an ICF are $1570 per month. These costs are adjusted quarterly.

b. Estimates obtained from the State Budget Agency.

APPENDIX C

SUPPLEMENTAL APPROPRIATION PROJECTION FOR CHOICE
FY 1990 and 1991

The supplemental appropriation projections below are the additional funding levels necessary for the CHOICE program to continue to provide quality services for individuals who are at-risk of institutionalization.

Tippecanoe county, one of the original CHOICE counties, had 307 clients in September 1989, before the program and budget restrictions had begun to affect the program. For the purposes of these projections, it is assumed that the client load of 307 was near the county's maximum active client level. This assumption was based on discussions with Area 4 Agency on Aging staff in which they stated that in August and September, the case load had evened out at around 307.

Tippecanoe County's clients represent .245% of the county's population. The following projections are based on this percentage, assuming that .245% of each CHOICE county's population will receive CHOICE services.

Two figures for monthly service costs are presented. The first cost, $502 per month, comes from the Task Force's October 23, 1989 report CHOICE: A Success in Local Service, a Crisis in State Management. It reflects the actual CHOICE service expenditures by Tippecanoe County for FY89. The second cost, $627 per month, comes from the Department of Human Services.

Using Tippecanoe County as a model, 1444 people would be served in the original 9 counties, and a total of 2868 people would be served in the 20 counties. The number of clients is multiplied by the monthly cost and then by 12 (12 months). It is assumed that the 11 expansion counties would not begin offering services until July 1990 (or FY91).

FY	Clients	x	Monthly Cost	=	Total Service Cost	Current Service Allocation	Necessary Supplemental Appropriation For Services
90	1444	x	$502		$ 8,698,656	$ 6 million	$ 2.7 million
91	2868	x	$502		$17,276,832	$ 7 million	$10.3 million
Total for biennium					$25,975,488	$13 million	$13.0 million
90	1444	x	$627		$10,864,656	$ 6 million	$ 4.8 million
91	2868	x	$627		$21,578,832	$ 7 million	$14.6 million
Total for biennium					$32,443,488	$13 million	$19.4 million

Senator **Coats**. Thank you very much, John. If you have to leave, we understand.

Mr. **Thomas**. I will stay. This is important.

Senator **Coats**. Terrific.

Eleanor, thank you for coming.

Ms. **Kinney**. Thank you. I am Eleanor Kinney, associate professor of law and director of the Center for Law and Health at Indiana University School of Law, Indianapolis. I gather that is your alma mater.

Senator **Coats**. That is my alma mater.

Ms. **Kinney**. Terrific. I bring you greetings from the school. I am very honored to testify here before your committee about some of the research that we are doing at Indiana University on home care, and specifically I would like to talk about two projects that we are engaged in. One is an evaluation of the Choice Program that the Department of Human Services engaged us to undertake last fall, and the other is a study that we did nationwide of home health agency responses to the Medicare claim denial crisis of the 1980's, and I think we have some interesting findings that I would like to touch on briefly and they will tie into some of Mike's comments that were made earlier.

These are two of many projects on long-term care that we are engaged in at Indiana University, Indianapolis, and various components of that school. Let me talk a little bit about the evaluation of Indiana's Choice Program. As I said, we were engaged last fall to undertake this evaluation. This is an undertaking really of three components of Indiana University. The School of Public and Environmental Affairs have undertaken the cost analysis, and the family research project in the Department of Sociology at Indiana University, Indianapolis.

We had two objectives in this evaluation. One was to answer the questions posed about the Choice Program that the General Assembly posed in its 1989-1990 budget legislation, and they posed four questions about cost and utilization of the Choice Program that we endeavored to answer in a relatively short time frame last fall. The second objective of our evaluation is to determine whether the Choice Program has achieved its goals of reducing long-term care cost, but also of enhancing the quality of life of Indiana impaired elderly and disabled and as well as their families. We feel that these are extremely important aspects of the Choice Program and that needs to be looked at in a systematic way. That part of the evaluation will take place this spring. It is a much more complicated effort, and I hope that the Legislature will await these results.

I have provided for the record a copy of part one of the evaluation entitled, "An Overview of Indiana Choice Program," which I hope you will include in the record, and it contains information particularly about our preliminary findings on the cost of the Choice Program.

I think in our efforts this fall, we concentrated on two problems for the Choice Program that the Department of Human Services expressed to us—these are cost and eligibility. Many were concerned that the Choice Program was too costly, and that we attempted to address this concern is precipitated by some other research, including the 6-year channelling demonstration on long-term care conducted by the Health Care Financing Administration, which tested whether substitution of home care for nursing home care would reduce health system costs. I think that you probably know that this demonstration and other demonstrations have indicated that while some cost effective substitution of services does occur, the enhanced availability of home care services does tend to create more demand for home health care and thereby is not quite as cost effective as one might suspect. The department was concerned about this; I think the General Assembly is concerned about it; and I think this is one of the things we attempted to address in part one of our evaluation and we will look at more closely this fall.

Let me tell you a little bit about what we found in attempting to answer the Legislature's questions. What were the number and demographic characteristics of recipients of home care under the Choice Program during fiscal year 1988-1989? We looked at about 1,400 Choice participants who were the ones that were served, and this indicated that two-thirds were over the age of 70 and nearly 20 percent were over 85. The majority were white and female. Nearly two-thirds had Medicare coverage, and 13.7 percent were on Medicaid. We looked at a great deal more demographic statistics that are contained in our report.

We then looked at what were the total and per recipient costs of providing home care services under the Choice Program in fiscal year 1988-1989. We found that the mean monthly cost for the typical person to participate in the Choice Program was about one-third of the monthly cost of being placed in a nursing home or a psychiatric facility or an institution for the developmentally disabled. Now, this was one-third of the cost that was actually expended. We looked at the data on the vouchers representing bills actually paid for home health care services and not just authorized. The mean monthly cost of providing services to a Choice participant came to $618. As I said, we calculated this estimate from State data and actual expenditures, and then we averaged them for each recipient. We compared this estimate to an estimated mean monthly charge of $1,800 for a Choice participant to be placed in a nursing home and about $2,200 if the participant had been placed in a psychiatric facility or an institution for the developmentally disabled. The details on how this cost analysis were derived are contained in greater detail in our report.

The General Assembly was concerned about what was the total cost savings for the State. Now, we did not address this in part one of our report. We simply looked at what was expended for a Choice recipient and what would be the cost for anybody, including a private family member, Medicaid State, Medicaid Federal, whatever, the total bill or the total charge for being in a nursing home or another type of long-term care institution. Nevertheless, I think that we can be assured that a Choice Program is relatively—has realized some cost savings. We are going to look more specifically at the cost savings that are realized by the State, but I think this is only a small part of the picture. We want to look at what is saved by society in general as well as the individuals and not simply the State or the Federal Government.

Another issue of grave concern to the State was were we really treating people who would otherwise be in a nursing home. That was of considerable concern. And I think we have to keep in mind that the decision to go into a nursing home is a very serious decision for people, for any person to make. We did find that 85 percent of the Choice participants indicated on their intake forms that they had not applied to a nursing home. I think that given what I just said about the enormity of the decision, we should not be too disturbed by that. But we did a comparison of Choice recipients, the ADL scores (activities of daily living scores) of our Choice recipients with a national sample of nursing home residents that is compiled by the Heartland Institute for Long-term Care, Aging and Disability at Indiana University School of Public and Environmental Affairs. We found that basically, these people in the Heartland sample and the people in our Choice Program were relatively consistent; in other words, that both groups had about the same activities of daily living scores. And therefore, I think we can be assured that while maybe some Choice recipients are not as disabled or limited as people in nursing homes, they are not that different from the nursing home population in general.

At any rate, we concluded in our report on the evaluation that the Choice Program does have the potential to save money and is saving money, particularly when we compare the cost of services to the cost of providing care in a nursing home. We look forward to part two of our evaluation when we look at the cost data in greater detail and then also assess the impact of the Choice Program on the quality of life of Choice Program recipients and their families.

Now I would like to just make a couple of points about our study of home health agency response to the Medicare claims denials in the 1980's. This is a study that we conducted at the Center for Law and Health in conjunction with Dr. Andrea Zeager, assistant professor of Public and Environmental Affairs at Indiana University, Indianapolis. I have also provided a copy of this report for the record.

What we were concerned about in this report were changes in Medicare coverage policies and tightening up of Medicare coverage criteria for home health care services which was reported before Congress in the late 1980's. There was a number of press articles about it, congressional hearings, some lawsuits and general concerns. Indeed, Congress in 1988 did mandate that the Department of Health and Human Services study this whole issue of increased Medicare denials for home health care, and they have subsequently come out with a report.

We found a number of very interesting findings which I do not have the time to go into here, but I do think that it is important to point out some of our findings with regard to how agencies responded to the changes in coverage policies in the 1980's. We found that the—the agency found that coverage policies were often arbitrary, inconsistently applied and often changing and that they were often ambiguous; and that because of a sort of changing set of rules they were faced with in the late 1980's and the increase of denials, they felt that they had to conform their behavior in a way that was detrimental to Medicare beneficiaries. Sixty-nine percent of our sample reported an increased number of denied claims, 73 percent found it more difficult to determine which services qualified for Medicare coverage, 79 percent of home health agencies found coverage decisions had become more arbitrary, 64.5 percent reported that they had decreased services to Medicare beneficiaries as a result of this situation, 87 percent reported that they had become more cautious about submitting claims for Medicare coverage, and 66.3 percent reported that they had become more involved in the Medicare appeals process. What this data indicates is that there is some considerable concerns among home health agencies about their relationship with the Medicare program.

I think some quotes might be in order here to give a flavor of some of our responses. One agency said, "We received a lot of denials, but there is no rhyme or reason; no pattern fits. Many of them are reinstated after informal review, but it still takes time and costs us money."

Another says, "Most coverage determinations are arbitrary and capricious. The fiscal intermediary told us they were required to deny $1 for every $5 paid."

Another comment: "Changes in Medicare coverage policies have forced us to refuse care to patients because we felt Medicare would deny it."

I think that this study—and I hope you take the time to look further at our results—is troubling, because we have to look at Medicare as it is engaged in a public/private partnership with home health agencies and private insurance companies. And I think we ought to be able to support our public programs to at least operate under a clear set of rules which are easily understood and uniformly applied, and I think our study found that this was not always the case with the Medicare program and home health care.

I appreciate the opportunity to testify here today and hope I can answer any questions if you would like.

[The prepared statement of Ms. Kinney follows:]

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PREPARED STATEMENT OF ELEANOR D. KINNEY, J.D., M.P.H. BEFOPE THE HEARING ON PUBLIC/PRIVATE PARTNERSHIPS: INNOVATIVE APPROACHES TO LONG-TERM CARE OF THE SUBCOMMITTEE ON AGING OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

January 17, 1990

INTRODUCTION

Mr. Chairman, I am Eleanor D. Kinney, J.D., M.P.H., Associate Professor of Law and Director of the Center for Law and Health at Indiana University School of Law -- Indianapolis. I am honored to testify before your Subcommittee on the research on home health care in Indiana and the nation that we are conducting at Indiana University -- Indianapolis.

Today, I would like to discuss two projects with you: (1) our evaluation of Indiana's CHOICE program; and (2) our study of home health agency response to the claim denial crisis of the 1980s for the AARP Andrus Foundation. These projects reflect our commitment to advancing knowledge on the financing and delivery of home health care services for the elderly and disabled of Indiana and the nation. The financing and delivery of home health care services have become crucial issues in the current debate over long-term care in America.

EVALUATION OF INDIANA'S "CHOICE" PROGRAM

In Fall 1989, the Indiana Department of Human Services (DHS) engaged Indiana University to evaluate Indiana's Community and Home Option to Institutional Care for the Elderly and Disabled (CHOICE) Program. This evaluation is a joint effort of the Center for Law and Health at Indiana University School of Law -- Indianapolis, the Health Services Research Center in the Indiana University School of Public and Environmental Affairs and the Family Research Project in the Department of Sociology, Indiana University -- Indianapolis.

The chief objectives of this evaluation are: (1) to answer the questions regarding the CHOICE program posed by the Indiana General Assembly in its budget legislation for fiscal year 1989-1990; and (2) to determine whether the CHOICE program has achieved its goals of reducing long term care costs and enhancing the quality of life of Indiana's impaired elderly and disabled as well as their families.

Our evaluation has two parts. Part I, completed in December 1989, is an analysis of the demographic characteristics of CHOICE participants and a preliminary cost analysis of the CHOICE program. For the record, I would like to provide the Subcommittee with a copy of our report, entitled "Part I: An Overview of Indiana's CHOICE Program." Professor Robert M. Saywell and Associate Dean Mark S. Rosentraub of Indiana University's School of Public and Environmental Affairs had the lead in conducting the analysis contained in this report.

This Spring, we will proceed with Part II of the evaluation to determine the impact that CHOICE has had on the lives of CHOICE participants both in terms of dealing with their disabilities and also in improving the quality of life of participants and their families. Professor Suzanne K. Steinmetz, Professor of Sociology and Director of the Family Research Project, along with myself, will conduct this part of the evaluation.

Background on the CHOICE Program. CHOICE is a case management program for community and home services to coordinate services at home for elderly and disabled persons at risk for institutionalization. CHOICE services include: attendant care, homemaker services, respite care and other services for primary or family caregivers, adult day care, home health services and supplies, home delivered meals, transportation and other services necessary to prevent institutionalization of eligible individuals when feasible. DHS administers the CHOICE program and contracts with area agencies on aging throughout the State to provide the case management services. The CHOICE program is regarded as the funding source of last resort for direct services after other state, federal and private funding sources are exhausted.

The Indiana General Assembly established the CHOICE program in 1987. The basic concept for the program was inspired by similar state-sponsored home care programs in Wisconsin and other states.[1] The program was established in 1988 as two pilot projects in

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[1] See National Governors Association, State Long Term Care Reform: Development of Community Care Systems in Six States (1988).

Tippecanoe County in Area IV (Lafayette) and in Knox and Davies counties in Area XIIIA (Vincennes). The General Assembly's initial appropriation was $1.5 million for State fiscal year 1988 and State fiscal year 1989 ($750,000 per year). The General Assembly has continued to support the program on a pilot basis with the following appropriations: a supplemental allocation of $5 million for State fiscal year 1989 (for a total of $7.5 million), $8.25 million for State fiscal year 1990, and $12.25 million for State fiscal year 1991. In February 1989, DHS expanded the CHOICE program into Martin County in Area XIIIA (Vincennes), all counties in Area XV (Mitchell) and Allen County in Area III (Fort Wayne). DHS has announced but not implemented additional program expansions.

Eligible individuals for the CHOICE Program are Indiana residents who are at least 60 years of age or older or disabled because of a severe, chronic disability attributable to an indefinite physical and/or mental impairment. The statute also requires that the individual meet criteria, developed by the CHOICE board, that the individual's impairment places him/her at risk of institutionalization.

Cost and eligibility are two controversial issues for the CHOICE program. Many are concerned that the CHOICE program will not accomplish cost savings. This concern is precipitated by prior research, including the six year Channeling Demonstration on long term care conducted by the Health Care Financing Administration (HCFA), which tested whether substitution of home health care for nursing home care would reduce health system costs.[2] This and other community care demonstrations indicated that, while some cost effective substitution of services does occur, the enhanced availability of home health services tends to create more demand for home health care thereby increasing overall expenditures for long term care.[3]

Preliminary Findings of Part I of the Evaluation. Part I of the evaluation addressed several questions posed by the Indiana General Assembly. These questions and our major findings in response are presented below.

- o What were the number and demographic characteristics of recipients of home care under the CHOICE Program during fiscal year 1988-1989?

The analysis of 1,462 CHOICE participants indicates that the great majority -- two thirds -- were over age 70 and nearly 20 percent were over 85. The majority were white (94.7 percent) and female (67.8 percent). Nearly two-thirds (62.0 percent) had Medicare coverage and 13.7 percent were on Medicaid. Additional demographic data on CHOICE participants are contained in Chapter III of our report.

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[2] U.S. Dep't of Health and Human Services, Health Care Financing Administration. Channeling Effects on Formal Community-Based Services and Housing (1987).

[3] See Kemper, Applebaum & Harrigan, "Community Care Demonstrations: What Have We Learned?," Health Care Financing Review, 8:87 (Summer 1987); Kemper, "The Evaluation of the National Long Term Care Demonstration: Overview of the Findings," Health Services Research, 23:161 (1988).

- What were the total and per recipient costs of providing home care services under the CHOICE Program in fiscal year 1988-1989?

We found that the mean monthly cost for the typical person to participate in the CHOICE program was approximately one-third the monthly cost of being placed in a nursing home, psychiatric facility or institution for the developmentally disabled. The mean monthly cost of providing services to a CHOICE participant was $618. We calculated this estimate from State data on actual expenditures vouchers received and paid from program funds, averaged on a monthly basis for each recipient. We then compared this estimate to an estimated mean monthly charge of $1,846 for a CHOICE participant to be placed in a nursing home and an estimated mean monthly charge of $2,285 if the participant had been placed in a psychiatric facility or an institution for the developmentally disabled. The estimated cost of nursing home placement was derived from the average base rate of either intermediate or skilled nursing care facilities plus the average base rate of add-on services, e.g., occupational therapy, physical therapy, etc.

The General Assembly also wanted to know what the total cost savings in fiscal year 1988-1989 realized by the State due to recipients of home care services under the CHOICE Program being diverted from long term care facilities? In the short time frame we had to complete Part I of the evaluation, we were unable to delineate the share of individual costs borne by the State. Our cost figures do not reflect a State savings per se but reflect the average total cost of the three alternative long term care settings. Only if the State pays the entire cost of each placement, regardless of setting, could we conclude that the CHOICE program cost differences presented above result in total savings to the State of Indiana. Further study is required to determine the extent to which the CHOICE program is actually "saving" State funds versus "saving" overall social expenditures (the total expenditures which include both the public and private share).

o What were the number of recipients of home care services under the CHOICE Program who would have been placed in long term care facilities had they not received CHOICE services in fiscal year 1988-1989?

To address this question, we compared the limitations on "activities of daily living" (ADL) in a national sample of nursing home residents and with data on ADLs of CHOICE participants to provide a crude measure of the CHOICE participants who might be in nursing homes if in-home services were not available. The Heartland Institute on Long Term Care, Aging, and Disability at Indiana University's School of Public and Environmental Affairs maintains a national nursing home resident survey containing data on more than 1.3 million people. Each individual in this data base has been evaluated in terms of their abilities to perform six key ADL functions. Using the same six ADL functions, we found that 75.5

percent of CHOICE participants could not perform at least four of these functions, suggesting that these CHOICE participants might have been placed in nursing homes since they shared the same limitations as typical residents in the nursing home sample.

Concluding Comments. We concluded in our report on Part I of the evaluation, that, at this point in time, the CHOICE program has the potential to save money and is saving money when the cost of services is compared to the estimated costs of care in nursing homes and other long term care facilities. We believe that additional analysis is necessary to get a more accurate picture of what the CHOICE program costs the State particularly when compared to what the State would otherwise pay for nursing home and other long term care services for CHOICE participants. We look forward to Part II of our evaluation when we address this issue further and also assess the impact of the CHOICE program on other factors, namely quality of life indices, besides costs.

HOME HEALTH AGENCY RESPONSE TO MEDICARE CLAIM DENIALS IN THE 1980S

In 1988-1989, the Center for Law and Health conducted an empirical study of the response of home health agencies to increased Medicare claim denials in the 1980s. This study was funded by the AARP Andrus Foundation and Dr. Andrea Ziegert, Assistant Professor of Public and Environmental Affairs at Indiana University -- Indianapolis, was co-investigator on this project. For the record, I have provided a copy of our report to the AARP Andrus

Foundation, entitled: "Home Health Agency Response to the Medicare Claim Denial Crisis of the 1980s."

The 1980s witnessed sharply increased denial rates for Medicare home health claims precipitating grave concern among Medicare beneficiaries, home health agencies, Congress and courts about continued access to home health care services for the aged and disabled. In 1988, the United States District Court for the District of Columbia, in Duggan v. Bowen, 691 F.Supp. 1487 (D.D.C. 1988), ruled that thousands of Medicare beneficiaries had been denied home health care illegally as a result of improper administration of the Medicare home health benefit by HCFA and its fiscal intermediaries, i.e., private insurance companies and Blue Cross plans which actually administer the home health benefit on HCFA's behalf. Congress then mandated HHS to study the reasons for increased Medicare claim denials by the summer of 1989.[4]

This crisis raised questions about the fairness of the administration of the Medicare home health benefit. Do Medicare coverage policies or the manner in which they are implemented inappropriately curtail home health care for entitled Medicare beneficiaries? One concern is that the Medicare program denies claims for home health benefits that should be paid. A second concern is that Medicare coverage policies discourage home health agencies from even submitting claims to Medicare on behalf of

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[4] See U.S. Dep't of Health and Human Services, Health Care Financing Administration, Report to Congress and the Administrator by the Advisory Committee on Medicare Home Health Claims (July 1, 1989).

Medicare beneficiaries, thereby precluding a beneficiary's right to appeal what is in effect an adverse coverage decision.

In our study, we were especially interested in two coverage policies. The first were the Medicare waiver of liability rules which allow Medicare payment for noncovered services already consumed if the provider and beneficiary believed in good faith that the services were covered.[5] If an agency's Medicare claim denial rate remains under 2.5 percent for the previous quarter, the agency will enjoy a favorable presumption under the waiver of liability rules. The fiscal intermediary will then pay all claims qualifying for waiver of liability without examining individual claims and denying any claims found to be not covered.

The second policy of interest was the "no-payment" billing procedure which allows a home health agency to submit a questionable claim at the request of a Medicare beneficiary and not directly jeopardize its favorable waiver of liability presumption.[6] If the agency does not submit a no-payment billing, then the beneficiary does not obtain a formal coverage determination which is necessary to enable the beneficiary to appeal an adverse coverage determination.

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[5] 42 U.S.C. § 1395pp (1982 & Supp. V 1987); 42 C.F.R. §§ 405.195-.196 (1989); Health Care Financing Administration, Medicare Intermediary Manual § 3439 (1989); Health Care Financing Administration, Medicare Home Health Manual §§ 260-269 (1989).

[6] Health Care Financing Administration, Medicare Intermediary Manual §§ 3439.1-.3 (1989); Health Care Financing Administration, Medicare Home Health Manual §§ 261 & 430 (1989).

Our study was based on a mailed survey to a random sample of 3,000 home health agencies nationwide selected from HCFA's 1982 Provider of Services data tape, as updated. We received 532 responses for a response rate was 18.6 percent. As our response rate is low, our data only represent the experiences of the responding home health agencies. Nevertheless, these findings provide important information about implementation of Medicare coverage policy for home health services not available elsewhere.

Findings. This study revealed important information about how the federal government discharges its statutory obligations to beneficiaries of the Medicare program. Study findings demonstrate that administration of the Medicare home health benefit has been problematic and perhaps has even threatened access to the Medicare home health benefit for Medicare beneficiaries.

Most devastating were our overwhelming findings that coverage decision-making for home health benefits by fiscal intermediaries between 1985 and 1988 has been inconsistent, ambiguous and seemingly arbitrary. Data from responding home health agencies on their reaction to the Medicare coverage decision-making environment during this period are important:

- 69 percent reported an increased percentage of denied claims.
- 73 percent found it more difficult to determine which services qualified for Medicare coverage.
- 79 percent found coverage decisions had become more arbitrary.
- 64.5 percent had decreased services to Medicare beneficiaries.

- 87 percent had become more cautious about submitting claims for Medicare coverage.
- 66.3 percent reported becoming more involved in the Medicare appeals process.
- However, 56.5 percent reported that they had not increased their use of the no-payment billing procedure.
- No consensus emerged regarding lose of favorable waiver of liability status.

Home health agencies comments provided additional anecdotal evidence of the confused implementation of Medicare coverage policy by HCFA and its intermediaries:

> "We receive a lot of denials, but there is no rhyme or reason. No pattern fits. Many of them are reinstated after an informal review, but it still takes time and costs us money."
>
> "The most disconcerting effect seems to be a lack of consistency on regulations; nurse reviewers are inconsistent, supervisors are inconsistent, and the HCFA regional office is inconsistent. To further 'muddy' the situation, opinions among and between regional offices differ as well."
>
> "Most coverage determinations [are] arbitrary [and] capricious. The fiscal intermediary told us they were required to deny $1.00 for every $5.00 paid."
>
> "Changes in Medicare coverage policies have forced us to refuse care to patients because we felt Medicare would deny it."

Not all comments of responding home health agencies about the Medicare coverage decision-making environment during the late 1980s were negative. One home health agency respondent even thought that tightening coverage decision-making in the late 1980s had been beneficial to the industry: "I believe that with appropriate documentation and careful evaluation the changes have a positive impact in most instances."

Our findings on operation and management of the waiver of liability rules were especially interesting. Waiver of liability experience is an important indicator of a home health agency's ability to understand Medicare coverage policy and apply it correctly in making decisions about whether to submit individual claims for payment. Of responding home health agencies, 33 percent lost their favorable waiver of liability presumption in 1988. Our empirical analyses found that three out of ten fiscal intermediaries had a statistically significant influence on whether home health agencies lost the favorable waiver of liability presumption in 1988. These findings are troubling given that Medicare is a nationwide program and its administration of its coverage and payment policies should be uniform nationwide as well.

It is also remarkable that one third of home health agencies analyzed did not use the no-payment billing procedure in 1988, despite HCFA manual instructions requiring home health agencies to have a policy on no-payment billing for questionable claims and to inform Medicare beneficiaries of the availability of this procedure when the agency decides not to submit a claim. This finding goes to the heart of the issue of whether there is a process in place to protect the right of a Medicare beneficiary to appeal all coverage denials, including those made implicitly by home health agencies when they decline to submit a claim. There is such a process but it is often not used. Thus, as a practical matter, beneficiaries may not always be informed about their right to appeal an implicit coverage denial by the home health agency and cannot access the administrative appeals process to challenge private decisions about benefits in the government entitlement program, Medicare.

In sum, HCFA and fiscal intermediaries develop and implement coverage policy and adjudicate coverage in ways that often impose barriers for beneficiaries in obtaining the home health benefits to which the Medicare statute suggests they are entitled. Indeed, nearly 97 percent of responding home health agencies found that HCFA's written and unwritten Medicare coverage rules are ambiguous. A maze of complex and inaccessible rules imposed by both HCFA and individual fiscal intermediaries define coverage in an inconsistent and constantly changing fashion. Home health agencies are then punished financially through the operation of the favorable waiver of liability presumption if they make too many mistakes in applying these inconsistent and constantly changing coverage rules. They are even punished if they file too many no-payment billings on behalf of beneficiaries who believe services should be covered Medicare benefits and want to protect their right of access to the administrative appeals system to challenge a private coverage decision by the home health agency.

Medicare coverage rules and their implementation effectively put home health agencies in a bind. Specifically, home health agencies that do least to challenge the system on behalf of their clients are rewarded and those that aggressively try to obtain services for their clients are penalized. The comments of one home health agency dramatically demonstrate this bind and its unfortunate consequences:

> "Our agency in the past three years has become extremely cautious regarding which claims will be accepted under the Medicare program and the length of time these clients will be covered under Medicare. This conservative application of the Medicare rules and regulations has resulted in few denials for our agency. However, I really question if home care for our clients could have been eligible for additional coverage under Medicare if our agency hadn't been forced to take such a conservative approach to applying Medicare's rules and regulations due to past and current problems with the Medicare system."

CONCLUSION

I hope that our research will contribute to the greater understanding of innovative approaches to long-term care that can be achieved through a public/private partnership. In conclusion, I would simply make two observations.

Regarding the CHOICE program, I believe that the State can serve effectively as a coordinator of in-home services for the elderly and disabled in an effective and cost efficient manner and greatly improve the quality of life of Indiana's elderly and disabled at risk of institutionalization. It is our hope that the evaluation of the CHOICE program which we have embarked on will assist the State in developing a stronger CHOICE program that can serve effectively in the role of marshalling federal, private and also state in-home services for those in need.

I also believe that our study of the response of home health agencies to the Medicare home health claim denial crisis of the 1980s speaks to the public/private partnership in forging innovative approaches to long term care. Simply, the Medicare program is predicated on a public/private partnership between the federal government, private insurance companies and providers for the financing and delivery of all kinds of health care services, including home health care, for its beneficiaries. It is crucial that the federal government clearly specify the coverage and payment policies by which it will engage in this partnership in an open, fair and consistent manner so that providers and also beneficiaries are aware of Medicare coverage and payment policies and conform their conduct and expectations accordingly.

Thank you for the opportunity to present the findings of our research to your Subcommittee. If we can be of further assistance, please let us know.

Senator COATS. Thank you very much, Eleanor. Thorough presentation.

Jeff, thank you for coming over and giving the State's perspective. We look forward to your testimony.

Mr. RICHARDSON. Thank you very much. First let me say that I want to say how happy we are that we are a part of this program. We want to recognize Members of both parties and congressional delegation and also in the House and Senate in Indiana who work so closely with us not only on this issue but a variety of issues in our department.

If I can briefly give you an overview of the Department of Human Services, because I think it will give you an appreciation for how this particular hearing affects a number of programs that we work with over the course of a given year. We have about 1,000 employees with a $250 million budget that works with thousands of Hoosiers throughout the State in the areas of housing, community, and social services, which includes such programs as the fuel assistance program, the commodities program, weatherization program, SSBG money (social service block grant money), which includes adult and child day care and a variety of other social services, the aging division, disability determination, and vocational rehabilitation. A lot of these programs have suffered cuts over the last several years from the Federal Government, and it has an impact not only on those specific programs, but a number of these same people who have problems as it relates to health are also the same people that have problems in relation to housing and in relation to their disability determination, fuel assistance moneys support, and the like.

We are especially glad, again, to be here to talk about how that interrelates because we feel the only way that we can solve these problems is working with you, the Senate, working with the House and working with the Indiana delegation here, and the House and Senate to solve these problems jointly. We do not feel that anyone, any particular person or any particular party, has any one answer to this; and we think the only way that we will be able to come to any kind of solution in this area or any other area that my department works in is through your support and your efforts as well as others like Representative Thomas who has been a leader in many of these areas, not just in the long-term health care area.

We also have a problem that is basically out of our control and one that was mentioned earlier. And I do not feel I need to go into great detail again, but we have an exploding population in that not only are people living longer, but because of technology, we have a number of disabled people who are living longer and living better lives. But as we learned at the Conference for Social Concerns that a number of people on this panel and others in the audience were involved with, we have some extraordinary situations that we did not even have 5 or 10 years ago.

One of the more moving testimonials that was given, and very tragic I might add, was a woman who had a child who had a spinal injury when the child was 1 year old and the child is now 4 years old, and she told us that last year alone it cost $1 million to care for that child in the hospital. Now, this was in context of home health care and also medical costs in general, and she suggested, and again I thought made a convincing argument, that she would like that child to come home. And she said that she could care for that child at home for $750,000 a year, thus saving the Government $250,000.

Now, this is the kind of choice that we are given, the kind of situation that we will be presented with in the future, not perhaps that extraordinary or of those amounts of dollars, but given that choice, we can rationally say that this child should be cared for at home. But when you look at the costs involved, $750,000, that alone could wipe out one area agency on aging budget alone who are now serving hundreds of people, and it is difficult. And I know being in the commissioner's office and you being in the Senate and you being in the House, these are the kinds of choices that we will be presented with, not that often I hope, but nonetheless, we have to come to terms with these kinds of questions, these kinds of choices. And again, we look forward to working with you in that area.

With the Choice Program, a number of areas have already been covered by Mike, John, and Eleanor, and I do not think I need to elaborate on those now, but I would like to say we are serving some 1,000 people in nine counties, as John said. We hope that the supplemental budget will pass either at the $7.75 million level or I believe John is still thinking about moving forward with his initial recommendation of $10 million. I know there are other people looking for some additional funding. But approximately $20 million will have been spent in this biennium.

One of the issues that has come up with cost and what the pay back is is interesting to us. We do want to save money; we do want to get people to participate in cost share; and we do want people to appreciate the benefits they are receiving. But we contend that even if it is a break-even proposition, that this program is worthwhile. We feel that people who wish to stay at home—and most do, if not all—should be able to, and that even if we are not saving millions of dollars over the course of the many years that we see this program existing, we hope that we can meet all people's wishes of keeping them at home while not losing money, while breaking even at best. But certainly if we can save money, we are certainly working toward that goal, we will move in that direction.

In that parity, Mike mentioned earlier the Medicaid waiver which we filed on January 3. This was done through the very good efforts of Geneva Shed, who is the director of the Choice Program, and her staff and also Suzanne Magnet and Steve McCafferty, staff over at the Department of Public Welfare, which was done in less than a month. We were told by our colleagues from the various States that—we interviewed about this program in Wisconsin, Illinois, and Minnesota—that it would take us at least a year to get this waiver pulled together, and we did it in less than a month. I think that underscores the commitment of the department and the governor's office and others who have been very involved in trying to push this program forward and again certainly Representative Thomas.

Now, let me just briefly mention that the waiver will cover case management, homemaker, personal care, adult day health care, respite care, and other services that U.S. Department of Health and Human Services permits to be covered by the waiver. And we are very anxious to hear a response from that, and I know, Senator Coats, that you also are very much out front on this waiver issue.

As I mentioned before, we have met with our colleagues from Wisconsin, Illinois, and Minnesota. We have received a lot of information from other States. We have received a lot of help and advice from Eleanor's study and certainly from Mike, Scott, Julie Kegle, John Cardwell, and a number of other people who have worked very closely with us over the past several months to try to get the program on course. We did have somewhat of a rocky start, but we have learned from our colleagues in many other States that they, too, have had that same kind of start; and many of them in their 8th, 9th and 10th year of the program are still fine-tuning it, still polishing it to try to make it a better program. I want to give special thanks, also, to Pam Carter, who is the health and human services liaison with the governor's office, and she's worked very closely with us over the course of the last several months also in guiding us and helping us get this program moving forward.

I have other comments that I would like to make about the program in general, but I think it might be more appropriate to do that in the question and answer session and let Scott give his assessment of the program.

Senator COATS. Very good. Thank you very much.

Scott, thank you for coming today.

Mr. SEVERNS. The perspective that I hope to represent here today, Senator Coats, is that of an advocate for consumers of long-term care. Over the last 12 years of my life, virtually every working day has been involved in working in some relation to long-term care in my work at Legal Services, and since 1984 in the private practice of law, representing individuals who face this problem; in my work as policy analyst for United Senior Action and the National Citizens Coalition for Nursing Home Reform, working on long-term care, quality issues as raised by nursing homes; and now as president of a rapidly growing association called the National Academy of Elder Law Attorneys, a group that now numbers some 500 attorneys around the country whose practices are primarily focused on the needs of an aging population.

The current work around the Choice Program, I feel, provides us with the best model for an entirely new vision of how we deliver long-term care. The current long-term care system for delivery and for financing, I think, is one of probably the most—from my experience in working with seniors—gut wrenching issues that they face. The taxpayer-supported money that the State of Indiana controls funds approximately $500 million to two out of three people in nursing homes and similar institutions on an annual basis. In contrast to that, if you add together all of the services that go to support people in their own homes, you come up with a figure somewhere between $20 and $30 million. This current system is simply unacceptable to most elderly people and most disabled people, and it leads me to believe in concert with what we have seen happen with the Catastrophic Bill that tinkering around the edges with this system is never going to be sufficient.

There are some elements about the system that absolutely have to be reversed. The current system encourages institutionalization, and I think, more than I could ever put into words, the opening scene from the videotape "We Can't Afford to Grow Old" illustrates the alien environment, the sense of loss of normalcy that goes with an institutional placement. The second aspect of that is that it takes the natural care givers, the family, the friends, out of any role that they can meaningfully play and reduces them to mere visitors. The nursing home environment, while it can be stimulating for the most part, creates increased dependence.

My own grandmother was a lady who lived into her 80's and suffered from phlebitis of her legs, which caused her legs to swell. She could not stand, and in her latter years it was very difficult for her to stand and walk. But her life was wrapped up, among other things, in being able to cook. If she had not been able to stay in my mother's kitchen with whom she lived during her latter years and continue that activity, very much of the quality of her life would have been gone. And I can remember the instances where my mother would say, "Mom, sit down. Your legs will swell," and Grandma would go right on cooking because that was part of what made life worth living, even though it was painful and even though in some respects it could threaten her health. This element of participating in normal activities of life simply is not possible in most instutitional settings.

And finally, the characteristic that I think I want to dwell on the most is the fact that the current system forces people into poverty. All but the most affluent of people will face impoverishment at the hands of long-term care and be made dependent on a dehumanizing welfare system.

Last night I went through some case files that we are handling in the office and pulled out some examples of what happens when middle class people are confronted with a welfare system that attempts to conform them to an economic style to which they are unaccustomed. Let me just summarize those very briefly. They are tabbed in the handouts. These are all cases of people who were admitted to nursing homes, spent their resources down until the point that they qualified for Medicaid. Medicaid in Indiana is limited to individuals who have less than $1,500 in countable resources, and it is the application of that $1,500 resource limit which particularly impacts most people.

In the Case No. 1, a grandson had undertaken the care of both his double amputee grandfather who was still living at home and his 77-year-old grandmother who had entered a nursing home. He encountered long lists of verifications that he was expected to obtain from the—by the Welfare Department to prove that his grandmother and grandfather were out of money. At a hearing some 6 months after he first encountered this and after he had obtained legal representation, it was established that his grandmother, in fact, met all of the financial eligibility requirements; but because back at the time that he applied he was unable to get such things as a formal appraisal of two weed-overgrown lots up in Pulaski County, he was denied—his grandmother was denied for failure to submit proper verifications. At the hearing, the hearing officer dismissed his case because he had failed to appeal that denial within 30 days after it was received. Two weeks after that denial was received, his grandmother died. Six weeks after it was received, his grandfather died. They left a bill of well over $10,000 in medical expenses that simply were never met because he failed to conform their lives or be able to demonstrate that their lives conformed with the means testing that Medicaid requires.

Case No. 2 is similar. A niece of an 86-year-old man in a nursing home was the victim of case worker errors. The verifications were, in fact, available but was denied erroneously. But in the meantime while all this was being straightened out—and it took approximately 3 months—she took a conservative approach and allowed his Civil Service pension and Social Security to accumulate in his bank account, not knowing exactly how to spend it. And as a result, even though she was denied for the reason that the case worker was in error, as a result of the income having built up in her account over those next 3 months, Medicaid denied her uncle coverage for those 3 months because in those months, he had more than $1,500 in the bank. So he died with $4,048 and $9,000 in unpaid medical bills.

Case No. 3 involves an 86-year-old lady who was denied Medicaid because her son failed to take account or failed to know that among her assets—he had taken account of the fact that she had cash value of life insurance that would count toward the $1,500 limit and had taken account of her savings account. But because she had $20 in her personal needs account at the nursing home that he had failed to account for, she was denied coverage for the October bill which totaled $2,000 because she was $9.58 over the limit.

Case No. 4 involves a man who had leukemia. He was suddenly diagnosed and admitted to the hospital for approximately 5 months. He accumulated during that time $150,000 in hospital bills, but during each of those months that he was in the hospital, he was determined by the Welfare Department to be over the Medicaid resource limits by a maximum of $1,555.44. Included among his resources were a horse drawn wagon and buggy each valued at $100, an old truck camper that was valued at $200 and two old cars that did not run, each valued at $50.

Case No. 5 illustrates the case of the wife of a 74-year-old Alzheimer's victim who received a notice from the Welfare Department approximately 1 year after he had spent down and qualified for Medicaid that a year earlier than that, they had discovered that he had an account at Naval Avionics in the credit union, and they demanded to know what happened to that account. This was a year before he became eligible. Ultimately, of course, she explained this account was applied to his long-term care need, but she received a notice threatening to terminate him if they did not receive it by January 9. The postmark on the notice was January 8.

Finally, Case No. 6 involves simply something we see in our office with virtually every Medicaid applicant. It is a little form from the Welfare Department that says sign this blank release form; do not date it; do not write anything else on it. Simply sign and return it. Write us a blank check to obtain confidential information about any financial issue that we choose to inquire about from any source. These encounters are not simply the excesses of bureaucracy. These are symptomatic of a system that says in order for you to receive help, you sustain a burden of proof of showing us that you are not only poor but poor within our definition.

These kinds of instances simply illustrate one of the complexities of means testing a program that provides the care for two-thirds of Indiana's nursing home residents and has the potential to get into our home care program. The strengths of the Choice Program that, I think, make it a new paradigm for how we approach long-term care are obviously the fact that the person stays in their community. They stay close to their friends and family and their source of informal care given.

Second, it establishes a spirit of partnership between Government assistance and family and the recipient. Only that assistance which is needed and cannot be provided otherwise is provided through Choice.

Third, there is an emphasis through this kind of care on the capabilities of the person, not simply their disabilities. And by being in control of their environment, they can control their lives. And that kind of sense-of-control and self-determination has a major impact on the quality of care that is provided, because people who are totally debilitated and totally deprived of ordinary rights and their own financial resources are seldom people who are going to complain about inadequate care.

Fourth, the Choice Program, although it is designed to be funding of last resort and helps people obtain assistance through the other systems out there like Medicare, supplementary insurance, and other sources they may have available to them, provides service as a gap-filler on a sliding fee scale. It avoids the welfare mentality of assistance that enforces poverty and regards each person as a potential cheater and allows them to maintain some dignity about the way they approach care.

We have an extreme interest in the long-term care initiative that was talked about in the first panel, but I think realistically we have to recognize that that is an initiative that may benefit my generation. It is not likely to be of much help to people who are now 60, much less those who are now 80. We have to come up with new ways in the short run of making the system more humane. Thank you.

[The prepared statement of Mr. Severns follows:]

PREPARED STATEMENT OF SCOTT R. SEVERNS

I. Relevant background and affiliations of Scott R. Severns in respect to Long Term Care of Older Americans:

A. Director, Nursing Home/Senior Law Project of Legal Services Organization of Indiana, 1978-1984.

B. Private practice of law focused primarily on the legal needs of the elderly, SEVERNS & LEWIS, 1984--.

C. Policy Analyst, United Senior Action of Indiana, 1984--.

D. Board Member/Program Vice President, National Citizen's Coalition for Nursing Home Reform, 1984--.

E. President, National Academy of Elder Law Attorneys,1989--.

F. Board Member, Strategic Planning Committee, Visiting Nurse Service of Indianapolis, 1987--.

G. Founding member, Indiana Home Care Task Force, 1986--.

II. Indiana's new home care program, known as the C.H.O.I.C.E. Program (Community and Homecare Options to Institutional Care for the Elderly and Disabled) provides a model for new approaches to meeting the care needs of an aging population.

A. The current long term care financing and delivery system constitutes one of the deepest fears of the aging population.

B. This year, taxpayer money controlled by the State of Indiana will provide roughly $500 Million to support approximately 2 out of 3 people in nursing homes and similar institutions. Only $20-30 Million will be provided to help two to three times as many equally impaired elderly who are living in the community.

C. The current system of long term care financing and delivery is extremely unpopular because it disenfranchises people needing this assistance in a variety of ways:

1. The elderly and disabled person who needs assistance are usually moved to an alien environment.

2. Many natural care-giving roles of family-members are replaced by nursing home staff.

3. The nursing home resident becomes more dependent and debilitated in this environment because very little opportunity for self-determination, productivity and self-expression.

4. A long term care need usually results in impoverishment for all but the most affluent people and makes then dependent on a dehumanizing welfare system.

D. Key elements of the C.H.O.I.C.E. Program address these major failures of the current long term care system:

1. The person stays in his/her own environment which is familiar, under his/her control, close to his natural sources of support (family, friends) and adaptable to changing circumstances.

2. A spirit of partnership is established between natural care givers and community based assistance.

3. Emphasis is placed on the capabilities of the individual and only assistance necessary to help person cope with impairments is provided; client-directed approaches to care and rehabilitation are prmoted.

4. The individuals is helped to access benefits through Medicare, private insurance, etc.; supplementary assistance on a sliding income scale without first requiring the person to exhaust life-savings. The "welfare mentality" to assistance that enforces poverty and regards each person as a potential cheater is avoided.

E. Reform of the long term care system must remove the fear of unnecessary institutionalization, loss of individual identity and loss of one's life savings to gain popular support.

APPENDIX

EXAMPLES OF MIDDLE CLASS PEOPLE'S
ENCOUNTER WITH THE WELFARE SYSTEM WHEN
THEY NEED LONG TERM CARE ASSISTANCE
DRAWN FROM THE CURRENT CASEFILES
OF SEVERNS & LEWIS

CASE 1

A grandson, who had a wife and two children and was holding two jobs was also attempting to look after the needs of his double-amputee grandfather at home and his 77-year-old grandmother who had entered a nursing home. He made Medicaid application on her behalf when the elder couple's finances were exhausted.

The grandson was given lengthy lists of verifications to be submitted to the Welfare Department about his grandparents personal financial affairs. His grandmother's application was denied because he failed to obtain all of the verifications requested, particularly an appraisal of the value of two overgrown lots in a defunct "resort development" in a distant county.

His grandfather and grandmother died two weeks and six weeks respectively after the denial notice was sent. Five months later he was referred to counsel by the nursing home for help appealing the denial and obtaining help with the nursing home bill totalling over $10,000.

At a hearing it was established that grandmother met all financial eligibility requirements for the period in question. The caseworker had been given releases of information to obtain bank balances but had demanded that the grandson obtain them. The grandson's submitted property tax statements from the lots showing their assessed value at $30 but these had been rejected by the caseworker and a full appraisal demanded which the grandson had tried but been unable to obtain.

Despite the showing that the grandmother met all eligibility requirements, however, the hearing officer dismissed the appeal because it had not been filed within 30 days of the day it was mailed to the grandson.

NOTICE AND CERTIFICATE OF ACTION
MEDICAL ASSISTANCE

State Form 1110R3/DPW Form 619M(Rev 1-84)

904

NOTICE TO APPLICANT / RECIPIENT

See the back of this form for important information about your responsibilities and appeal rights

Last name, first, middle [redacted] c/o [redacted]	County Marion
Street Address [redacted]	Case Number (Type Code Serial) MA-49-57430
City, State, Zip Indianapolis, IN 46222	Application Date 8-1-88
	Mailing Date of Notice 9-6-88

☐ Your application for Medical Assistance was approved

☐ Your Medicaid coverage is effective ______

☐ Nursing Home Cases Only You are responsible for paying the following amount (liability) each month to the facility where you are residing

$ effective	$ effective	$ effective

☐ Your eligibility for Medical Assistance was determined under the Spend Down provision in accordance with 42 CFR 435.732
Your Spend Down amount is

$ effective	$ effective	$ effective

This means that you will be eligible to receive Medicaid coverage when you incur allowable medical expenses equal to or exceeding your Spend Down amount each month. In order to receive a Medicaid card each month you must provide to the County Welfare Department proof of your medical expenses (paid or unpaid) such as bills, receipts, or written statements from medical care providers.

☒ Your application for Medical Assistance was denied

Reason(s) for denial: Refusal to provide or cooperate in obtaining information necessary to determine eligibilit 1. Appraisal of property located in Pulaski County, Indiana, 2. Proof of any income received off of the property in Pulaski County, 3. Savings (see below)

Supporting law(s) or regulation(s): 470 IAC 2.1-1-2

☐ Effective ______ the following action is being taken by the County Welfare Department

☐ Your Medical Assistance is being continued

☐ Your liability is $ ______

☐ Your Spend Down amount is $ ______

☐ Your Medical Assistance is being suspended until ______

☐ Your Medical Assistance is being discontinued

Reason(s) for the action:

Supporting law(s) or regulation(s) for an adverse action:

Additional Information: account number at Bank One, 4. Failure to verify Bank One savings balances for 5/1, 6/1, & 7/1, 5. Failure to verify Bank One checking account no. 4342366 balance for 5-1-88, 6. Jet Credit Union account no. 68221 balances for 5/1 & 7/1/88 and ownership of $2000.00 on deposit at Jet Credit Union, 7. Verification of Blue Cross premium & coverage for [redacted] & [redacted] 8. Medical bills from 5-1-88 to present for [redacted] & [redacted].

HOOVERWOOD NURSING HOME, 7001 Hoover Rd., 46260

Signature of County Director of Public Welfare: Lois G Drake

Date of action by County Director: 9-6-88

SDPW USE ONLY	Acct	Stat	Cent. Files	Reason Code for Denial	DPW Form 174 number
					147

Distribution of Copies: 1 Applicant or Recipient 2 State Department (if applicable) 3 County Department 4 Health Care Facility (if applicable)

CONFIDENTIAL

INDIANA DEPARTMENT OF PUBLIC WELFARE

REGARDING: [redacted], Appellant
CASE NUMBER: MA-49-57430
ISSUE: Denial of Medical Assistance to the Aged
(MA) Application

FINDINGS OF FACT AND DECISION

The Administrative Law Judge, having heard the evidence presented by the Parties, now makes the following Findings of Fact:

1. That an application for Medical Assistance to the Aged for [redacted] [redacted] was filed with the Marion County Department of Public Welfare on August 1, 1988 by [redacted] [redacted], the applicant's grandson.

2. That the appellant meets the citizenship requirement as found in 42 CFR 435.402.

3. That the appellant meets the State residency requirement as found in 42 CFR 435.403.

4. That the County Welfare Department denied this application effective September 6, 1988 for the reason that "Refusal to provide or cooperate in obtaining information necessary to determine eligibility." 470 IAC 2.1-1-2. Specifically "1. Appraisal of property located in Pulaski County, In. 2. Proof of any income received off of the property in Pulaski County. 3. Savings account number at Bank One. 4. Failure to verify Bank One checking account no. 4342366 balance for May 1, 1988. 6..Jet Credit Union account no. 68221 balances for May 1 and July 1, 1988 and ownership of $2,000.00 on deposit at Jet Credit Union. 7. Verification of Blue Cross premium and coverage for [redacted] and [redacted]. 8. Medical bills from May 1, 1988 to present for [redacted] and [redacted]."

5. That on September 6, 1988 the County Welfare Department mailed notice of the reason for and effective date of this action as required by 42 CFR 435.912. Notice was mailed to [redacted] [redacted] c/o [redacted] [redacted] at [redacted] N. [redacted], Indpls, In 46222.

6. That a request for a hearing was received at the Indiana Department of Public Welfare on March 16, 1989 from Scott R. Severns, Attorney representing [redacted].

7. That a hearing was scheduled for and heard on May 23, 1989 under the provisions of 42 CFR 431.200 et seq. and 470 IAC 1-4 et seq.

8. That pursuant to 42 CFR 435.907 the agency must require a written application from the applicant, an authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.

9. That the agency must allow an individual or individuals of the applicant's choice to accompany, assist, and represent the applicant in the application process. (42 CFR 435.908)

10. That [redacted] [redacted] filed the application on behalf of his grandmother, with whom he resided from age 1 until adulthood, as she was in a nursing home unable to handle her own affairs due to the severity of her impairments and loss of faculties, and her spouse, his grandfather, was physically disabled with multiple impairments.

11. That [redacted] [redacted] did acknowledge that he received the Notice and Certificate of Action (619M) dated September 6, 1988 and discussed it with his grandfather.

12. That [redacted] acknowledged that he was aware of the appeal rights as stated on the reverse side of the notice.

13. That pursuant to 470 IAC 1-4-3(b) unless otherwise provided for by statute or regulation, appeal requests by recipients or applicants shall be filed in writing with the county or state department of public welfare not later than thirty (30) days following the effective date of the action being appealed and the hearing shall thereafter be scheduled in the County where the appellant resides.

14. That [redacted] [redacted] testified that he had discussed the denial with his grandfather and they had decided to pursue selling the property in Pulaski County, however this was not accomplished. His grandfather died on September 21, 1988 and his grandmother died on October 30, 1988. Further action on the denial or disposal of Pulaski County property was dropped.

15. That an appeal was not filed on behalf of the applicant until more than six months after the Notice of Denial was issued.

16. That this matter of the timliness of the filed appeal was taken under advisement by the Administrative Law Judge on May 23, 1988.

17. That the appeal filed on behalf of the applicant far exceeded the time allowed under 470 IAC 1-4-3 and therefore upon consideration of the above facts, the Administrative Law Judge dismisses the matter without review of the merits of the denial due to an untimely filed appeal.

DECISION

Based upon the Findings of Fact, the Administrative Law Judge dismisses the matter without review of the merits of the County Department's action to deny the application, due to the untimliness of the filed appeal.

Beth Overmyer
Beth Overmyer
Administrative Law Judge

CASE 2

A niece of 86 year old man in nursing home who had spent down all of his assets on his care applied for Medicaid for him. She was given a list of verifications to obtain and spent several days locating his paperwork, writing and visiting insurance companies to obtain statements about his insurance, etc. His application was denied because the caseworker erroneously concluded from an insurance identification card that he had life insurance which she though might have a cash value and that a form to be sign by the 86 year old man had not been returned.

After the niece was referred to counsel, it was shown that the insurance card referred to his health insurance and there was no life insurance with any cash value. It was also shown that the caseworker had received but overlooked the form signed by the nursing home resident.

However, after the denial but before the caseworker's errors were discovered, the niece, not knowing how to apply his income checks had permitted 3 monthly Civil Service and Social Security income checks to build up in his account. He died with $4,048 in his account and over $9,000 in unpaid medical bills.

An estate was opened and the old gentleman's remaining money was applied to his outstanding medical and tax bills.

The niece, a social worker in the public schools, made three trips for a hearing on the case. The first time the hearing was continued because a previous hearing ran late. On the second date the Welfare Department attorney agreed to a settlement but the agreement was later vetoed by a Medicaid supervisor. On the third date the hearing officer took all the evidence, ruled that there were no good cause exceptions to the rule that a Medicaid applicant may not have more than $1500 on the first day of any month for which assistance was sought, even when the problem is caused by agency error.

CONFIDENTIAL

INDIANA DEPARTMENT OF PUBLIC WELFARE

REGARDING: [redacted]

CASE NUMBER: MA-49-57588

ISSUE: Effective Dates of Medicaid Coverage

FINDINGS OF FACT AND DECISION

The Administrative Law Judge, having heard the evidence presented by the parties, now makes the following findings of fact:

1. That an application for Medical Assistance to the Aged for [redacted] [redacted] was filed with the Marion County Department of Public Welfare on September 6, 1988 by Doris Duncan, niece and Power-of-Attorney for Mr. H[redacted].

2. That Mr. [redacted] met the citizenship requirement as found in 42 CFR 435.402.

3. That Mr. H[redacted] met the State residency requirement as found in 42 CFR 435.403.

4. That the County Welfare Department denied this application effective October 18, 1988 for the reason that "no verification of Aetna Life Insurance Policy other than policy number was given. Cannot determine total resources of [redacted] H[redacted] at this time; also no. 750 signed by Mr. H[redacted] has not been returned."

5. That the County Welfare Department mailed notice of the reason for and effective date of this action as required by 42 CFR 435.912.

6. That no request for a hearing was filed concerning the denial of Mr. H[redacted]'s application on October 18, 1988.

7. That a Notice and Certificate of Action was mailed to [redacted] on April 14, 1989 stating Mr. [redacted]'s application for Medical Assistance was approved effective September 1, 1988; however, Medicaid would be discontinued effective November 30, 1989 as bank statements were not provided for December, 1988, January and February, 1989, to verify possible excess resources.

8. That although the discontinuance date was erroneously stated as November 30, 1989, other information on the notice indicated the discontinuance was supposed to be effective November 30, 1988.

9. That a request for a hearing was received at the Indiana Department of Public Welfare on April 20, 1989 from Scott R. Severns, Attorney, representing [redacted] [redacted] concerning Walter Hansberry.

10. That a hearing was scheduled for and heard on October 10, 1989, subsequent to several rescheduled hearings, under the provisions of 42 CFR 431.200 et seq. and 470 IAC 1-4 et sequentia.

11. That [redacted] [redacted] died on February 15, 1989.

12. That in March, 1989 a collateral verification from Aetna Life and Casualty that had been requested in the fall of 1988 was received in the County Department documenting [redacted] [redacted] had no life insurance, only health insurance through their agency. The caseworker initiated a contact with [redacted] [redacted] on March 28, 1989 whereby the County Department agreed to give reconsideration to Mr. [redacted]'s application for MA.

13. That the County Department rescinded the earlier denial of October 10, 1988 for reason that the life insurance policy in question was verified to be health insurance coverage and should not have been considered as a resource. The form 750 had been signed by [redacted] [redacted] on October 14, 1988 as requested, and the applicant's resources were under $1500 during the months of September, October and November, 1988.

14. That the insurance cards from Aetna Life and Casualty provided by Mrs. [redacted] at the time of application had information printed on the cards to substantiate they represented a Federal Health Benefit with control #065000-10-000 for Mr. [redacted].

15. That the caseworker interpreted the information on the cards as referring to a life insurance policy, and as the County Department had not received a response from Aetna Life and Casualty and Mrs. [redacted] was unable to obtain verification of a life insurance policy for Mr. [redacted] the application had been denied for reason that the worker was unable to determine total resources.

16. That on August 3, 1989 Mr. Scott Severns appeared with [redacted] [redacted] for another scheduled hearing in this matter. During a pre-hearing conference with Eugene M. Fife, Attorney for the County Department, and Harry Allen, Appeals Supervisor, the parties concerned reached an agreement whereby the County Department would rescind their action and grant MA eligibility effective September 1, 1988 through February, 1989.

[redacted]
MA-49-57588

17. That on August 3, 1989 Scott Severns signed the Notice of Hearing form withdrawing the appeal pursuant to adjusting action to be taken by the County Department. The Administrative Law Judge was informed the matter had been resolved, and both parties were told an official DISMISSAL NOTICE would be sent from the Indiana Department of Public Welfare.

18. That on August 8, 1989 the County Department requested another hearing be scheduled per phone call to the scheduling clerk in the Legal Division of the Indiana Department of Public Welfare. Mr. Allen stated this was necessary because the County Department would not be implementing the adjusted action as agreed on August 3, 1989.

19. That legal counsel for the appellant requested that the County Department be bound by their decision of August 3, 1989 to grant assistance to Mr. [redacted] through February, 1989, for reason that all parties had agreed it was a final determination with no equivocal provisions.

20. That no written notice or explanation was sent to Mr. Severns or Mrs. Duncan as to why the settlement was not binding; nor was any written statement sent to the Indiana Department of Public Welfare showing good cause as to why the settlement of August 3, 1989 was nullified and another hearing requested.

21. That the explanation of Mr. Fife and Mr. Allen at the hearing on October 18, 1989 consisted of statements indicating the agreement of August 3, 1989 was based upon their limited knowledge of the facts and misinterpretation of the evidence.

22. That it is the County Department's position that [redacted] [redacted] had resources in excess of $1500 in his checking account in December of 1988, January and February, 1989, and for this reason the adjusting action agreed upon with Mr. Severns on August 3, 1989 could not be executed.

23. That testimony of Doris Duncan substantiated some of Mr. [redacted] income accumulated in his checking account because he owed State and Federal taxes that had to be paid. Some amounts were paid to the nursing home, but Mrs. [redacted] took a conservative approach to the handling of her uncle's funds until she received notice from the IRS as to the amount of taxes owed.

24. That balances in Mr. [redacted]'s checking account were $2183.00 on December 1, 1989, $2642.15 on January 1, 1989 and $4048.70 on February 1, 1989 as verified by statements from Merchants National Bank and Trust Company.

[redacted]
MA-49-57588

25. That the resource limitation for an applicant who is single is $1500.00 pursuant to 470 IAC 9.1-3-17.

26. That pursuant to 470 IAC 9.1-3-17, possession of excess resources on the first day of the month renders an applicant ineligible for medical assistance for that entire month.

27. That verification submitted at the hearing confirms Mrs. [redacted] disbursed $4415.92 left in Mr. [redacted]'s account at the time of his death to pay his liabilities including the IRS, Hooverwood Nursing Home and Long Term Care Pharmacy.

28. That legal counsel for the appellant contended the monies in excess of $1500 would not have existed if the application had been correctly approved in October, 1989; that Mrs. [redacted] had made every effort to provide information necessary to determine her uncle's eligibility, and that upon his death she properly exhausted all of his assets to pay his bills. Therefore, concessions made by the duly authorized representatives for the County Department on August 3, 1989 were fair and equitable to both parties.

29. That Eugene M. Fife, III and Harry Allen, the County Department attorney and the appeals supervisor, respectively, are employees who have authority to make administrative decisions concerning recipients' eligibility for assistance and routinely represent the County Department in appeal hearings. Therefore, on August 3, 1989 neither Mr. Severns nor the Administrative Law Judge had cause to question the determination concerning Mr. [redacted]'s assistance. These County Department representatives accepted Mr. Severns' signed withdrawal and the provisions stated therein.

30. That on August 3, 1989 Mr. Fife and Mr. Allen had knowledge of Walter [redacted]'s bank account balances for December, 1988 through February, 1989.

31. That no other administrative personnel or witnesses were present on behalf of the County Department other than Mr. Fife and Mr. Allen to present any additional evidence or statements as to why the agreement of August 3, 1989 could not be honored and implemented by the County Department.

32. That the evidence submitted substantiates the County Department had sufficient verification to determine Mr. [redacted] was eligible for MA in accordance with financial standards set forth in 470 IAC 9.1-3 et seq. when the application was denied on October 18, 1988.

33. That despite inadvertent errors of the County Department in processing Mr. [redacted] application for assistance and abrogation of the agreement made on August 3, 1989, the issue to be determined is whether or not [redacted] [redacted] was eligible for MA for the months of December, 1988, January and February, 1989.

34. That as Mr. [redacted]'s resources were in excess of $1500 during the months in question, he did not meet the eligibility criteria for MA pursuant to 470 IAC 9.1-3-17.

35. That the applicable regulations provide no exceptions or good cause provisions that can be considered on a case-by-case basis in determining eligibility for medical assistance. However, in consideration of the agency errors that occurred in processing this case, the concessions made by Mr. Fife and Mr. Allen on August 3, 1989 were understandable.

36. That the most recent official action of the County Department on April 14, 1989 cannot be sustained as the notice incorrectly states medical assistance to Mr. [redacted] is effective September 1, 1988 and being discontinued November 30, 1989 instead of November 30, 1988.

DECISION

Based upon the Findings of Fact, the Administrative Law Judge hereby determines that [redacted] [redacted] was not eligible for MA for the months of December, 1988, January and February, 1989 for reason that his checking account accumulated resources in excess of the allowable amount pursuant to 470 IAC 9.1-13-17. The County Department must send a corrected notice of this determination.

Judith A. Powell
Judith A. Powell,
Administrative Law Judge

DATE: November 9, 1989

CASE 3

An 86 year old lady in a nursing home was denied Medicaid for October, 1989 because her son who applied for her did not know she had approximately $20 in her "personal needs account" at the nursing home. When added to the cash value of her life insurance and her remaining savings, the welfare department determined that she had $9.58 more than the permissible $1500 resource allowance on October 1 so denied help with her entire October bill totalling over $2,000.

NOTICE AND CERTIFICATE OF ACTION
MEDICAL ASSISTANCE

State Form 1110 (R 4 / 1-88) / DPW Form 619M

NOTICE TO APPLICANT / RECIPIENT

See the back of this form for important information about your responsibilities and appeal rights

943

Last name, first, middle [redacted] % [redacted]	County Marion
Street Address [redacted]	Case Number (Type, Code, Serial) MA-49-59340
City, State, Zip Indianapolis, Indiana 46260	Application Date 9-29-89 / Mailing Date of Notice 12-11-89

☒ Your application for Medical Assistance was approved

☒ Your Medicaid coverage is effective 9-89

☒ Nursing Home Cases Only: You are responsible for paying the following amount (liability) each month to the facility where you are residing

$ 560.00 effective 9-89	$ 939.00 effective 11-89	$ 1033.00 effective 12-89

☐ Your eligibility for Medical Assistance was determined under the Spend-Down provision in accordance with 42 CFR 435.732. Your Spend Down amount is:

$ effective	$ effective	$ effective

This means that you will be eligible to receive Medicaid coverage when you incur allowable medical expenses equal to or exceeding your Spend-Down amount each month. In order to receive a Medicaid card each month you must provide to the County Welfare Department proof of your medical expenses (paid or unpaid) such as bills, receipts, or written statements from medical care providers.

☐ Your application for Medical Assistance was denied

Reason(s) for denial:

Supporting law(s) or regulation(s):

☐ Effective ______ the following action is being taken by the County Welfare Department:

☐ Your Medical Assistance is being continued ☐ Your liability is $ ______ ☐ Your Spend-Down amount is $ ______

☐ Your Medical Assistance is being suspended until ______ ☐ Your Medical Assistance is being discontinued

Reason(s) for the action:

Supporting law(s) or regulation(s) for an adverse action:

Additional information: No retroactive coverage requested prior to 9-89. Resources exceed resource limitation of $1500 effective 10-1-89 in the amount of $9.28 in the form of cash value of policy bank balance and personal fund on hand at nursing home.

[redacted]

470 IAC 9.1-3-17

Signature of County Director of Public Welfare	Date of action by County Director 12-11-89

SDPW USE ONLY	Acct	Stat	Cent. Files	Reason Code for Denial	DPW Form 17A number 162

Distribution of Copies: 1. Applicant or Recipient 2. State Department (if applicable) 3. County Department 4. Health Care Facility (if applicable)

CASE 4

A man who was discovered to have leukemia and suddenly hospitalized from July through December, 1988. He was denied Medicaid assistance for over $150,000 in hospital bills because the Welfare Department concluded that on the first day of each month he was in the hospital, he had more than $1500 in countable resources. His "excess resources" never exceeded $1,555.44. Counted among his resources were a horse drawn wagon and buggy, each valued at $100.00, an old truck camper valued at $200, a horse trailer that was valued at $1000 for the two months he had it before it was repossessed and two old cars that did not run each valued at $50. Eventually, his brother sold and spent down his excess resources but because he had owned them on the first day of each month in question, he was denied Medicaid assistance for bills accrued during that month.

The case is pending review in court after having been turned down by a welfare department hearing officer.

PAC
STAMPER
[✓ CASE]
APPEALS
ABBOTT
JAFFEE

STATE OF INDIANA
EVAN BAYH · Governor

DEPARTMENT OF PUBLIC WELFARE
100 NORTH SENATE AVENUE · ROOM 701
INDIANAPOLIS, 46204

APR 2 8 1989

TO: H[redacted]
Monroe County Welfare Department
Scott Severns, Attorney
Robert Sembroski, Attorney

FROM: Indiana Department of Public Welfare
Hearings Section

RE: H[redacted] P[redacted]
MD-53-2523

Attached is a copy of the decision on the appeal hearing which was held on March 30, 1989.

If you are not satisfied with the decision, you have the right to request a review by the State Board of Public Welfare within ten (10) days of the receipt of this decision. Your request should be addressed to the Secretary of the State Welfare Board at the above address. If you desire the opportunity to present oral arguments to the State Board of Public Welfare, your request must be in writing and submitted along with the initial Board review request. The Board shall determine the length of oral arguments (470 IAC 1-4-6).

E. S. Jaffee
Lea E. S. Jaffee
Administrative Law Judge

LeAnn K. Abbott
LeAnn K. Abbott, Supervisor
Hearings Section

CONFIDENTIAL

INDIANA DEPARTMENT OF PUBLIC WELFARE

RE: [redacted], Appellant

CASE NUMBER: MD-53-2523

ISSUE: Effective Date of Medical Assistance to the Disabled

FINDINGS OF FACT AND DECISION

The Administrative Law Judge, having heard the evidence presented by the parties, now makes the following Findings of Fact:

1. That an application for Medical Assistance to the Disabled (Medicaid) was filed for [redacted] with the Monroe County Department of Public Welfare on October 27, 1988, by his brother/power of attorney.

2. That the appellant was seeking assistance effective July 1, 1988 as that was the month in which he became ill with leukemia and was hospitalized.

3. That the County Department granted assistance effective December 1, 1988, but not earlier as the appellant's resources prior to that date exceeded the resource limitation.

4. That the County Department mailed notice of its determination and the reasons for it as required by 42 CFR 435.912 on January 12, 1989.

5. That a request for a hearing was received in the Indiana Department of Public Welfare on January 18, 1989 from the appellant's attorney, Scott Severns.

6. That a hearing was scheduled for and heard on March 30, 1989 under the provisions of 42 CFR 431.200 et seq. and 470 IAC 1-4 et seq.

7. That the regulation governing in this case is 470 IAC 9.1-3-17 which states that a single applicant or recipient is ineligible for medical assistance for any month in which the total equity value of all non-exempt resources exceeds $1500.00 on the first day of the month.

8. That the appellant is a single individual.

9. That the County Department determined the appellant's resources on the first of each month for which assistance was requested but denied, to have been as follows:

	7-1-88	8-1-88	9-1-88	10-1-88	11-1-88
Savings Acct.	225.29	225.29	228.38	228.38	228.38
Checking Acct.	1007.23	948.05	1327.06	1002.46	820.56
Wooden Wagon	100.00	100.00	100.00	100.00	100.00
Buggy	100.00	100.00	100.00	100.00	100.00
Camper	200.00	200.00	200.00	200.00	200.00
Gremlin	50.00	50.00	50.00	50.00	50.00
1975 Cadillac	50.00	50.00	50.00	50.00	50.00
Stock Trailer	1000.00	1000.00	1000.00	(-0-)	(-0-)
Totals	$2732.52	$2673.34	$3055.44	$1730.84	$1548.94

10. That the appellant owned a third motor vehicle whose value was excluded.

11. That the appellant's attorney did not dispute the correctness of any of these figures but rather argued that some of these items should have been considered exempt and that even if he had resources in excess of $1500.00, the appellant should have been permitted to contribute the excess towards his large medical bills and thereby become eligible retroactively.

12. That there is no provision in 470 IAC 9.1-3-17, the regulation governing the amount of allowable resources, for reducing one's resources to gain eligibility retroactively.

13. That the appellant's attorney argued that $500.00 of the monies in the checking account should be excluded as "inaccessible" because the appellant had erred in balancing his checkbook in May, 1988 and discovered in December, 1988

that he actually had $500.00 more than he had realized, and also that all of his resources were "unavailable" because he was not well enough to liquidate them or to direct his power of attorney to do so.

14. That 470 IAC 9.1-3-16 defines resources as real and personal property owned by the applicant. It states that the resource must be "available" but defines an "available resource" as one which "the individual has the right, authority or ability to liquidate..."

15. That failing to correctly balance one's checkbook or to correct it upon receipt of monthly bank statements does not make the resource "unavailable".

16. That the appellant and/or his power of attorney had the legal authority to liquidate all of the resources and therefore they must be considered available as defined in 470 IAC 9.1-3-16.

17. That the appellant's former employer gave him a gift of $500.00 by putting that amount into his checking account in August, 1988 and the appellant's attorney argued that this amount should have been excluded as a resource.

18. That as explained in the Medical Assistance Eligibility Manual, Section 2210(g) the current month's income is not to be counted as a resource but "Income from previous months which may have accumulated is counted as a resource as is income retained beyond the month of receipt."

19. That the County Department correctly handled the $500.00 gift to his account: since it was received in August, it does not appear as part of the August 1 balance and if it remained and was part of September 1 balance then it was correct to have included it.

20. That the appellant's attorney argued that the wagon, buggy, camper and/or trailer should have been exempted either as household goods/personal effects or as necessary to the production of income.

21. That the appellant's minor daughter uses the trailer to transport 4H animals to the County Fair and the wagon is used for pleasure, to haul wood for the home or at times to carry feed for the animals, but it is the daughter alone and not the appellant who derives income from the 4H sales and therefore these items are not excludable as part of any activity producing income to the appellant.

[redacted]
MD-53-2523

22. That the appellant does raise some hay for sale but he testified that that hay is hauled not with the wagon but rather with a tractor; the County Department did exclude the tractor and all other equipment which it could identify as being used in the production of the hay.

23. That the buggy is solely used for recreation, driven by the appellant's mules.

24. That the camper is used solely by the daughter to stay at the County Fair.

25. That 470 IAC 9.1-3-17 does exempt household goods and personal effects and Section 2218.3 of the Medical Assistance Eligibility Manual explains that "Household goods are items of personal property customarily found in the home and used in connection with the maintenance and occupancy of the home. They include (but are not limited to) furniture, appliances, kitchen utensils, linens, television sets, etc. Personal items are those items of personal property which are worn or carried by an individual. Some examples are clothing, jewelry, hobby items."

26. That Section 2218.5 further states: "Recreational vehicles and campers which are not motorized, as well as trailers, boats, etc., must be counted as resources..."

27. That there is no basis in any of the above-cited regulations for exempting the appellant's camper, wagon, buggy or trailer.

28. That since the appellant did own non-exempt resources which exceeded the $1500.00 limitation on July 1, August 1, September 1, October 1 and November 1, he was ineligible for Medicaid for those months.

DECISION

Based upon the Findings of Fact, the Administrative Law Judge sustains the determination of the Monroe County Department of Public Welfare that the appellant was ineligible for Medical Assistance to the Disabled prior to December 1, 1988 as he had excess resources prior to that date.

[redacted]
MD-53-2523

COMMENT

At the request of the appellant's attorney, pending receipt of this decision and additional instructions therein, the Monroe County Department of Public Welfare agreed not to destroy any still existing applicant/recipient files for the period 1970-1975 in the Medical Assistance to the Disabled or Aged Programs. However, in regard to the continued preservation of the files by the Monroe County Department of Public Welfare, it is not within the scope of the Administrative Law Judge's authority to order the County Department to preserve these files; therefore, no ruling on the matter can be made.

Lea E. S. Jaffee
Administrative Law Judge

Date: April 29, 1989

CASE 5

The wife of 74 year old Alzheimer's victim who had spent down to Medicaid levels in 1989 recently received this notice from the caseworker telling her to explain what happened to money from his Naval Avionics Credit Union Account in 1988 by January 9, 1990 or face termination. The notice was mailed on January 8, 1990.

1-4-90

DPW Form 2014 Discrepancy Notice

Case Name	[redacted]
Case No.	MA 58849
Worker No.	984

[redacted]
Indpls In 46219

Dear

Federal Law (Section 2651 of Public Law 98-369) requires the Welfare Department to check case file information against information maintained by other State or Federal agencies. The information being checked concerns income (and resources) belonging to every person receiving Food Stamps, Medicaid, or AFDC.

The current review of your welfare records has identified a discrepancy that must be resolved. Information has been received that income was paid during 1988 to the following persons from the sources listed.

Recipient's Name	Source of Income	Type of Income
[redacted]	Naval Avionics Emp. Credit Union	interest bearing account

In order to remain eligible for benefits, you must assist in resolving this discrepancy:

1. You must provide information regarding the income source and the amount of income that is received or proof that the income and income source no longer exist; and
2. ~~You must sign the attached release of information and return it to the County Welfare office.~~

You must do both of the above by 1-9-90 or you will receive notice that your benefits will be terminated. If you try to get proof but can't or you wish to discuss this matter, you must contact

HELEN KUNZ at 924-7667 Monday thru Friday

from 10:00am to 3:15pm by the date above.

Remember you must take action by the deadline above or you may no longer be eligible for public assistance due to refusal to cooperate.

Helen Kunz
(Signature of County Official)

Marion County Welfare Department

SEVERNS & LEWIS
Attorneys at Law
490 Century Building
36 South Pennsylvania St.
Indianapolis, Indiana 46204-3509
(317) 633-4090

Attorneys:
BRUCE L. JONES
MARGARET W. LEWIS
M. JUDITH MURPHY
SCOTT R. SEVERNS
GEORGE G. SLATER

Fax No: (317) 633-4219

January 10, 1990

Helen Kunz
Marion County Dept of Public Welfare
Caseworker #984
1819 N. Meridian
Indianapolis, IN 46202

Re: [redacted] MA 58649

Dear Ms. Kunz:

In response to your letter of January 4, 1990, and mailed on January 8, 1990, we have enclosed verification of the closing date of Mr. [redacted]'s account and the closing balance. Mrs. [redacted] will also be providing a statement of how the funds were spent.

Paragraph 3373.1 of the Medicaid Manual states that the due date for requested information "should allow at least 7 days from the mailing..." As you can see from the enclosed copy of the envelope that the notice was received in, the date of mailing was January 8, 1990. Therefore, we request that Mrs. [redacted] be given until at least the 15th of January to comply with your request for information.

Sincerely,

Debbie L. Slate
Legal Assistant

enc.

STATE OF INDIANA
MARION COUNTY
DEPARTMENT OF PUBLIC WELFARE
1819 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46202

DO NOT FORWARD

SF 23451 (R/3-89)

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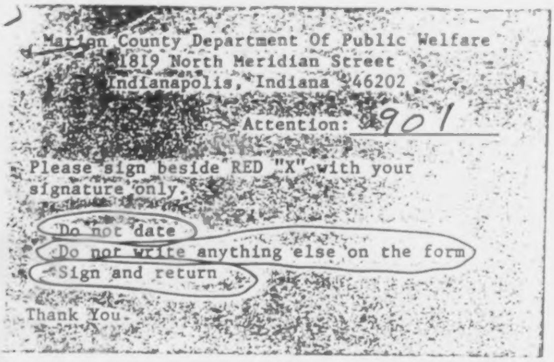
313629

[illegible] the Welfare Department to
[illegible] maintained by other State or Federal
[illegible] income (and resources) belonging
[illegible] AFDC.

CASE 6

Attached is an example of a release of confidential information that Medicaid applicants and recipients are routinely told they must sign in blank and give to their Medicaid caseworker. This one went to the daughter of an 81 year old Alzheimer's victim.



Marion County Department Of Public Welfare
1819 North Meridian Street
Indianapolis, Indiana 46202

Attention: 901

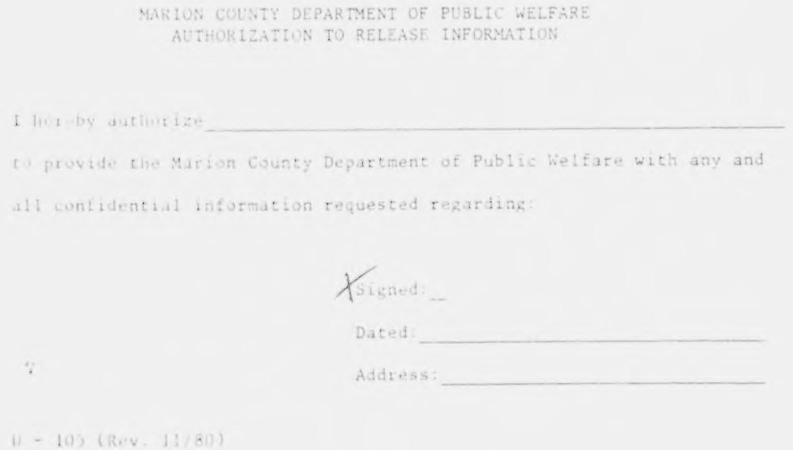
Please sign beside RED "X" with your signature only.

Do not date

Do not write anything else on the form

Sign and return

Thank You.



MARION COUNTY DEPARTMENT OF PUBLIC WELFARE
AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ____

to provide the Marion County Department of Public Welfare with any and all confidential information requested regarding:

X Signed: _

Dated: ____________________________

Address: __________________________

U - 105 (Rev. 11/80)

Senator COATS. Thank you very much, Scott, and thanks to all the panelists for excellent presentations. In the time that we have, I have a couple of brief questions and then again I would like to open it up to the audience, so you might be thinking of questions that you have for one or more of the panelists. I am wondering how much analysis has been made relative to the various options open to the State for participation in home health care services. Is Choice the choice, or are we studying and looking and contemplating other options in place of or in addition to Choice? And John, I think I will start that question with you and ask Jeff and then anybody else.

Mr. THOMAS. I might not be the most appropriate person to ask as to other alternatives, but I would also say that there are some features of the home care program, the Choice Program, that have been covered, such as the meals, the transportation, and case worker services that have been furnished in the past through other programs already in existence. But the home care program is the most comprehensive because it does apply to those persons who are in the risk of going to a nursing home because there are services they need to continue to exist in a humanizing fashion and either have to have those services performed for them in a nursing home situation or in their own home.

So I would defer to, perhaps Jeff, or others that could tell you what other alternatives are being considered.

Senator COATS. Jeff, go right ahead.

Mr. RICHARDSON. Gentlemen, Senator, also besides the traditional services that we have spoke of, let me just give you a quick overview what Choice does cover: Case management, homemaker, attending care, respite care, adult day care, home health services and supplies, home delivered meals and transportation. So as Representative Thomas said, it is quite comprehensive. That does not mean that we are not looking at the big picture. And by bringing our colleagues in again from Wisconsin, Illinois, and Minnesota, we looked at a variety of programs and again a number of—variety of ways to handle the situation, and I think we have a lot of work to do.

I think on the front end, though, we are very anxious to make sure that the Choice Program is working well, but we are certainly open and anxious to learn about other ways that we can work in this area at the statewide level. In addition to that, we are encouraging local levels to move forward with programs they may have. For example, in Bloomington they have a prescription drug assistance program, and we support and encourage that kind of development. We also know of several programs now throughout the State that the community action program agencies and the AAA (Area Agencies on Aging), are looking at possible mergers to provide better services to those people not only in the Choice Program area but a variety of services that we either fund through the Department of Human Services or they get direct grants from Washington or from private foundations to help people. And in all of those areas, we are hopeful that we can move forward, but I think our primary emphasis right now is, fair to say, is on the Choice Program.

Senator Coats. If it turns out and the results come back that seem to indicate that this will be a positive response to the elderly needs, will the State have the resources to expand this on a 92-county basis, and will it have the administrative ability to manage it on a 92-county basis? And how hard or how difficult is that going to be in the future?

Mr. Richardson. I do not know how difficult it will be. No problems, I am sure, in the years ahead. I think that our intention certainly is to go to 92 counties. And how quickly we move in that direction will depend upon the State Legislature and the governor and the various needs and multitude of needs that face the State. And Choice Program is certainly one of the top priorities of the governor and certainly of most State legislators, but I cannot speak for them as to how quickly we can go to the 92-county level. In part it depends on what we learn over the next 6 months to 18 months as far as costs go. We have just issued new guidelines and procedures that will hopefully be codified into rules this summer, and I think we will have a better fix at that time as to what the exact cost of a 92-county program might be.

Senator Coats. John.

Mr. Thomas. I might just add on the time factor that you have asked, Senator. The senior citizens organizations of this State have a slogan: 92 by 1992. That is not going to happen and I think realistically they know that. In talking to the governor last year concerning this exact issue, he indicated to me that he hoped that it could be put in place throughout the State within 6 to 8 years. That would have been 1995 to 1997. I would certainly like to see it statewide fully implemented by the mid 1990's. I think that is a realistic goal.

I think that the studies that are being made will show the value of this program both as far as finances are concerned and also as to the quality of the program is concerned. If that is the case, I think it is wise for us, it is the humanizing thing for us to do, to make it statewide as soon as we can. But again, Senator, we need some help Federally in order to help us do that because the argument is made, "Well, here, this is all State dollars." The Federal Government will benefit financially from the program by the diversion, and yet they are not willing to put the money in. And so I think any help that you can do will be a benefit in implementing the program. But certainly on a time schedule by 1995, I think, is very realistic both administratively and financially, for the taxpayers of this State.

Senator Coats. We do have just a few minutes before the end of the program, and I would again like to open it up to the audience for possible questions, and other panelists may have comments also. But are there any questions from the audience?

Audience Member. Senator, I find it hard to believe that a program such as Choice, at a cost of roughly $600 per participant, would keep someone out of a nursing home. I do not think that would be a very high risk client that you are serving. Also, you stated that 85 percent of the people you were serving never applied to a nursing home for admission, which means that had they applied, they may have been eliminated by the preadmission screening program. So I think there is some specious figures and arguments in those figures that you are offering. Also, a comment that I would make, that if the State truly believes that Choice Program is an option and it is preferable to nursing home care, which I subscribe to, why do you cap it at a percentage of nursing home care? Why don't you fight to make sure that that program succeeds? Do not stop short. Go ahead and champion that cause.

Mr. **Richardson**. I apologize if I said there was a cap or if someone else said that. Actually, the figure that we are using now is an average, the bench mark. So, in fact, you are correct that you can go right up to the cost of a nursing home or a cost of an instutitional care. And if there was a misunderstanding there, I apologize. But it is a cap. I am not really sure what to say except that we do feel that this program is worthwhile. And it is not a question, I think, of pitting the nursing home industry versus people who want to stay at home. I think the evidence that we have to date is that most, if not all, people would prefer to stay at home, and that is the premise we are working on. That does not mean that nursing homes, therefore, are bad or that all of them are bad or everyone in a nursing home is miserable. We are not suggesting that. But the evidence is overwhelming right now, if possible, people would prefer to stay at home.

Now, as to your point about data collecting—and Scott has been very much an advocate for this as well and he may want to speak to this—but you are also right that we need to collect better data and more data to know exactly what the needs are and how we can best respond to them, including knowing the eligibility standards, the kind of people we are getting in the program, in fact, are they all at risk of moving into a nursing home. And that is one of the things we are looking at along with a variety of other issues, and I think as Representative Thomas said is one of the reasons we are not ready to go statewide yet. We need that kind of information to make this a program, cost—quality program, cost effective program, and one that we can all be proud of, and I think as someone said at the very outset of this panel, one that can possibly be a model for the rest of the country, and that is essentially the goal that we are trying to reach.

Mr. **Thomas**. Let me just say to the question about the cap, the only cap is that the cost of the services to be provided in the inhome care services may not exceed the cost of the nursing home. So at one-third of the cost, we are far from getting close to what the cap is; we have a long way. So there is no legal cap to it that is going to stop us short for a long time. One-third, as the statistics are at this moment, of the cost of the nursing home is no problem whatsoever. It is funding that we need the money for.

Mr. **Sullivan**. Also, that $618 figure is the amount of money expended from the Choice Program only. It does not include Medicare, Medicaid and all the other funding sources. So to say that it is not taking care of at-risk clients is incorrect because the Medicare may be several hundred dollars a month, Medicaid may be several hundred dollars a month and Choice Program may be several hundred dollars a month. The reason that the Choice Program figure is indicated is we are comparing that figure to the State's share of the Medicaid nursing home cost, and those are two like items. When you start throwing numbers around, when you compare the cost of the Choice Program versus the State's share they are expending on Medicaid for nursing homes, those are two very comparable items.

Also, to be eligible for the Choice Program, a person must undergo a stringent medical screening exam which is very similar to the pre-admission screening process in a nursing home. So they are taking care of clients that are at risk.

Ms. KINNEY. May I make a comment, please?

Senator COATS. Sure.

Ms. KINNEY. I think one of the things we found in our initial study was when we compared the Choice participants with residents of a nursing home, they did not look markedly different in terms of the limitations that they had. Now, I think you do have a problem in terms of the fact that only 85 percent—that 85 percent indicated on the form that they had not applied to nursing home. But you need to appreciate what it means to make that kind of decision. It is not a consideration of equal options. One of the things we plan to do this spring is to look at that particular issue much more—in much greater detail, what is involved in making that decision. Some of the research on that decision is recounted in part one of the evaluation that I have given to Senator Coats.

Finally, I think we need to look at some of the services—the constellation of services that are provided to individual Choice participants, and we are going to do that this spring as well. We have really just begun to look at this program systemically in our evaluation. I think there are lots of questions that were raised and things that I think we can look at that will enhance the implementation of this program to make sure that we are providing services to those people who really need it and that we are providing them in the most cost effective way.

[Additional statements and material submitted for the record follow:]

STATE of INDIANA

1816

INDIANAPOLIS, 46204

STATE BUDGET AGENCY
FRANK SULLIVAN, JR., DIRECTOR
THE GOVERNOR'S LONG TERM CARE INSURANCE PROJECT
HARRISON BUILDING, SUITE 402
143 WEST MARKET STREET
317/232-2024

EVAN BAYH
Governor

PREPARED STATEMENT OF THE INDIANA LONG TERM CARE INSURANCE PROGRAM
CAROL COWGILL, PROJECT DIRECTOR

Regarding the
INDIANA LONG TERM CARE INSURANCE PROGRAM

As Requested By
Senator Dan Coats
Indianapolis, Indiana
January 17, 1990

Senator Coats, members of the Subcommittee on Aging, thank you for inviting me here today to discuss the State of Indiana's plans for addressing the long term health care needs of Indiana's elderly citizens.

My name is Carol Cowgill and I am Project Director for the Indiana Long Term Care Insurance Program. I am submitting this testimony also on behalf of Pamela Carter, the Governor's Executive Assistant for Health and Human Services, and Chairperson of the Steering Committee for the Governor's Long Term Care Insurance Project.

The enabling legislation for the Indiana program was passed unanimously by the Indiana General Assembly (SEA 107 of 1987), possibly because this is a win-win-win program....for the state and federal government, for elderly consumers of long term care, for the taxpayers of the state, and for private insurers and private providers of long term health care.

Following passage of this legislation, Governor Robert Orr's and Governor Evan Bayh's administrations have worked diligently to design and implement the program in partnership with the private sector, with guidance and consultation from Dr. Mark Meiners, and as one of the eight states participating in the Robert Wood Johnson Foundation's Program To Promote Long Term Care Insurance For The Elderly. We are attempting to create an innovative program which coordinates public and private sector financing of long term care, specifically by integrating private insurance coverage with the state Medicaid program.

In order to accomplish this objective, the State needs authority from the federal government to waive the asset spend-down requirements of the Medicaid program. We would like to thank Senator Coats for sponsoring Senate Bill 1998 which provides this authority and we are very gratified that his bill was passed by the unanimous consent of the U.S. Senate in November, 1989. If the bill is passed by the U.S. House of Representatives this year, it will provide the authority needed for Indiana and eight other states to implement demonstration programs like the Indiana Long Term Care Insurance Program.

As per your request, Senator Coats, I will summarize very briefly the problems and the solutions envisioned in the Indiana Long Term Care Insurance Program, with special emphasis on the affordability, equity, and consumer protection concerns associated with the program.

As you know, historically most long term care has been provided in nursing home settings at an average cost of about $22,000 per person per year. Nearly half of the total cost of nursing home care has been financed out-of-pocket by individuals and their families. State Medicaid programs have financed most of the balance of costs, but only after families have exhausted nearly all of their financial resources. Only a small portion of the total nursing home costs -- only 4% in Indiana -- have been financed by Medicare or by private insurance. Under the current system, the middle class elderly often become impoverished by the costs of long term care and find themselves on Medicaid, a program originally intended for the poor. Consequently, major and growing portions of state Medicaid budgets -- nearly $500 million a year in Indiana -- are devoted to financing long term care.

Long term care financing issues are becoming even more important as the American population grows older; for example, the number of Americans over the age of 85 - an age group particularly in need of long term care services - is expected to grow three to four times as quickly as the general population. Up to 40% of all elderly Americans are likely to spend a portion of their lives in a nursing home.

For these reasons, the State of Indiana has sought to find a more rational and humane method of financing long term care for the elderly, one that builds and improves upon the current financing system and one that can be implemented efficiently and effectively for Indiana's citizens. We know from national attitude surveys, from an Indiana University survey of the elderly population, and from statistics on the income and asset levels of the elderly, that as many as 50% to 75% of our citizens are willing and able to pay for private insurance policies that meet their long term nursing home and home health care needs.

The Indiana program is geared not toward people already eligible for public programs but toward people at risk of becoming eligible for public programs by spending all of their resources to the point of impoverishment. The Indiana program is one of several programs being undertaken by the State to reduce the traditional bias in favor of financing institutional care, in this case by requiring that qualifying insurance policies must include home health care as well as nursing home coverage.

Indiana's public and private officials have been working for the past year to design a program that complements the spousal impoverishment provisions retained in the Medicare Catastrophic Coverage Act.

The Indiana Long Term Care Insurance Program has been designed to ensure fiscal neutrality and ease of administration for the state, to foster insurance industry flexibility and innovation in long term care product design, and to maximize both the affordability of insurance and the opportunity for consumer choice among a wide array of long term care insurance products. Consumer protection is provided through a set of minimum standards that insurance products must meet in order to qualify for participation in the Indiana Program. These standards exceed the guidelines recommended by the National Association of Insurance Commissioners and adopted as rules by the Indiana Department of Insurance.

In order to serve the broadest possible range of income groups in the simplest and most equitable manner, the Indiana program is designed to provide Medicaid asset protection equal to the amount of insurance benefit payments used after the age of 65 for Medicaid eligible long term care services. Consumers have the option of purchasing a qualifying policy with the amount of insurance coverage (and asset protection) that they believe they need and can afford.

After depleting insurance benefits and becoming eligible for Medicaid, insured individuals will contribute income toward the cost of care in the same manner as other Medicaid eligible individuals. For services covered in insurance policies but not yet covered by the Indiana Medicaid program (e.g., certain home care services), eligible consumers may apply to the state for participation in other public programs which do provide these services (e.g., CHOICE and other home care programs administered by the Indiana Department of Human Services).

As currently designed, the Long Term Care Insurance Program's sliding scale approach to asset protection will provide maximum consumer choice and consumer savings, while enabling the state to assure that Medicaid expenditures with the program will not exceed Medicaid expenditures in the absence of the program. No one will become eligible for Medicaid earlier than they would have in the absence of the Long Term Care Insurance Program. The program should result in public savings for individuals whose insurance coverage exceeds the value of their assets, because insurance will finance care beyond the point at which these individuals would have spent down to Medicaid eligibility.

Current Indiana statute provides that in order to qualify for the Long Term Care Insurance Program, insurance policies must provide coverage for at least twelve months. This twelve month minimum has merit for three primary reasons: first, premiums are affordable to a majority of people for this level of coverage; second, the length of stay in nursing homes is less than one year for a majority of people (63-73% depending on the source); and third, a majority of the spend down group (86% according to Indiana statistics) spend down within one year.

Additional minimum standards have been adopted by a task force which includes consumers and representatives of the insurance industry. Among these consumer protection standards are the following:

1. Insurers must clearly disclose prior to sale and with all policies the availability of state sponsored counseling, consumer education, complaint handling and appeal mechanisms.

2. Policies must guarantee consumers the option of buying inflation protection or must provide another mechanism by which the value of coverage will keep pace with changes in the cost of care.

3. Policies must cover home health care, care in skilled nursing facilities and care in intermediate care facilities, and may cover additional services including but not limited to respite care, adult day care, custodial care and a variety of other home care services.

4. Coverage must include treatment of Alzheimers disease and senile dementia.

5. Prior hospitalization or institutionalization may not be used as a condition of eligibility for benefits in a less restrictive setting.

6. Policies must be guaranteed renewable.

Insurers have agreed in principle to identify and provide the state with the types of data needed to administer the long term care insurance program and to evaluate its effectiveness. For example, insurers have agreed specifically to track the characteristics of persons denied coverage due to underwriting. After the first two years of operating the Indiana Long Term Care Insurance Program, the state, in conjunction with insurers, will evaluate the need for additional public/private approaches to serving persons with limited access to coverage due to economic or health status factors.

Several task forces currently are working in Indiana on resolving implementation issues related to coordinating public/private service delivery for the Long Term Care Insurance Program.

For example, one task force is designing the consumer education and information component of the program, which we consider to be one of the most important functions the State will perform in this public-private partnership. While the State still is in the planning stage for this part of the program, plans to date call for installing a state toll-free long term care insurance hot line, for developing public service announcements and brochures, and for working with Indiana's area agencies on aging and senior interest groups to develop a network of trained persons knowledgeable about long term care generally and about the Indiana Long Term Care Insurance Program specifically. Indiana statute provides that long term care counseling will be available to persons age 65 and over though the Welfare Department or the Department of Human Services. In addition, the Indiana Department of Insurance is expanding its consumer education and complaint handling capabilities and plans to develop a volunteer network of technical assistants.

If granted a waiver, the State of Indiana expects to demonstrate that insurance is a viable method of financing a greater portion of long term care expenses than has been the case to date. The state seeks to demonstrate that it can simultaneously enhance the quality and affordability of long term care insurance coverage available to its citizens, reduce financial hardships for the elderly, and offset future public expenditures for long term care.

The Indiana approach can improve the well-being of hundreds of thousands of elderly persons, making it possible for them to plan ahead to meet their long term care needs without fear of impoverishment. Today, as we begin a new decade and prepare for a whole new century, we believe that this demonstration program will yield answers to many key implementation, marketing and utilization questions and will provide critical data needed to inform the debate over a national approach for financing long term care.

Thank you, Senator Coats, for providing the State of Indiana with this opportunity to address the Senate Subcommittee on Aging.

PREPARED STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Chairman, we are pleased to submit testimony on the important subject of long-term care insurance and S. 1998 before your committee.

The Health Insurance Association of America (HIAA) represents some 350 insurance companies which write about 40 percent of all health insurance in this country. HIAA's overall position on the financing of long-term care for the nation's elderly is as follows:

- While the current "system" is flawed, the financing of long-term care is complicated and requires a thoughtful solution, not a rush to judgement.
- Fiscal realities and other national priorities make it irresponsible to place the financing burden primarily on the nation's taxpayers. All elements of society -- individuals, families, volunteer organizations, employers, and insurers must also play a vital role.
- There is a growing and critical role for private insurance to provide a better means of financing long-term care for those who can afford to protect themselves.
- There is a continued and indeed, greatly improved role, the government can play in financing long-term care for those without adequate resources to protect themselves.
- There continues to be a critical government role, independent of financing care, in data collection and research to further our collective knowledge about who needs long-term care, what services should be provided, and what the total costs to society will be.

In addition, HIAA firmly believes that cooperative public-private financing and delivery arrangements should be promoted on an experimental basis such as that proposed in S. 1998. A comprehensive national policy should be based on a full understanding of the alternatives and their cost-effectiveness.

Research and demonstration efforts such as the Robert Wood Johnson planning grants to the states to develop public-private financing and delivery models for long-term care will enable both the public and private sectors to test and identify the most effective financing approaches.

Background

While there is increasing public awareness that long-term care is not a benefit of Medicare or Medicare supplemental insurance policies, our country is only beginning to grapple with the many facets of paying for prolonged health and custodial services by a growing elderly population. The statistics speak loud and clear:

- The lifetime risk of entering a nursing home is at around 40 percent; it is almost 50 percent for women.
- When an elderly person spends more than $2,000 per year out-of-pocket on health care, 80 percent of that is spent on nursing home care.
- New estimates peg the yearly cost of nursing home care at an average of $37,000.
- About 9 million people will require long-term care by the turn of the century. Most will not use nursing home care. Currently about 70 percent of the elderly receive all their care in their homes from family members and friends. Another 30 percent also receive some type of paid assistance.
- Providing long-term care is more than a matter of financing it. Long-term care delivery systems are fragmented and piecemeal. In many cases where a nursing home placement is not desirable, it is often the only choice when other forms of long-term care assistance such as home health aides, adult day care and respite help simply do not exist.

New Developments in Long-Term Care Insurance

A recent national survey conducted by the University of Maryland's Center on Aging found surprising willingness by the public to purchase a long-term care plan if it met their long-term nursing home and home health care needs. Overall, over one-half of those surveyed indicated they would pay $100 a month for such a plan. In addition, two-thirds of full-time workers said they would be more willing to purchase a policy if it were offered by their employer, even if the employee paid all or some of the premium.

The long-term care insurance market is developing rapidly, as evidenced by the number of companies developing products, the number of individuals covered and the variety of products being developed. There are now over 100 companies selling a long-term care product and almost all of this growth is since 1985. Today, over 1.3 million persons have purchased a long-term care plan. Coverage is available through the individual and employer market, in conjunction with life insurance, and as a member of a retirement community.

More importantly, the products themselves are changing. The earlier products tended to be more limited. For instance, they covered only stays in a nursing home and then only following a hospital stay. But virtually all the newer products offer coverage of nursing home and home health care, without institutional gatekeeping mechanisms like prior hospitalizations.

Instead, benefits are often triggered based on the need for assistance in personal care functions such as bathing, walking and dressing. In addition, they provide inflation protection against future long-term care costs. We will see a continued trend toward more comprehensive and liberal benefit provisions as the market place becomes more competitive.

Appropriate Public Financing Role

According to the Employee Benefit Research Institute, an estimated $56 billion was spent on all long-term care services in 1987. Over half, $30.6 billion, was paid by the public sector. Assuming no change in our current financing system, the Congressional Budget Office has estimated that current spending could increase between 50 and 200 percent by the year 2000.

Given today's fiscal realities and competing national priorities, we cannot expect the public sector to take on such an enormous and unwieldy financial responsibility. Instead, HIAA believes that public policy should be targeted toward finding ways to more effectively use the private resources already being spent for this care, thereby reducing future public long-term care expenditures. Those who can afford to protect themselves should be encouraged to do so.

It is not the role of government to protect and preserve assets or income levels of individual citizens against the various contingencies of life. In general, it is the responsibility of individuals to plan for their own needs to the maximum extent possible. It is the role of government to provide sensitive and responsive support to those who face needs beyond their individual financial capacity to deal with them.

The government should target its limited resources to assist those who can least afford such protection. Private insurance products are not designed for, nor do they lend themselves, as financing vehicles for people who are already quite old, disabled, or poor. Providing care for this population should be the objective of the public sector, and reforms are needed to improve the government's ability to act as a responsible safety net for those who must rely on it.

The complexity of developing a workable public-private partnership calls for innovation, experimentation and evaluation. We feel strongly that the demonstrations permitted under S. 1998 would greatly contribute to our overall understanding of how to build the optimal mix of public and private financing for long-term care.

Educating the Public

The need for better consumer education is the responsibility of both the private and public sectors. It is virtually impossible to sell a product to someone who already believes they have it. However, this is where we find ourselves with long-term care insurance. Education should begin early, so that working age people can plan for their potential long-term care needs while they have the income to do so. This is perhaps where the Robert

Wood Johnson projects have already had their greatest impact. Clearly, educating individuals in these eight states is one of the linchpins to the entire proposal.

State Regulatory Environment

Long-term care insurance is a new product that continues to evolve. Insurers need a state regulatory environment which is sufficiently flexible to allow for the development of new and different products but is equally effective in protecting consumers. In December 1986, the National Association of Insurance Commissioners (NAIC) first adopted model legislation that successfully balances these two objectives. Since then, the model statute has been amended several times to better meet consumer needs.

By the end of 1989, 37 states had passed legislation or adopted regulations that met or exceeded the provisions of the model bill. We are encouraged at the speed with which states have acted to govern this new product. As an industry, we must minimize the potential for consumer abuses if we are to sustain a viable market. Passage of the NAIC model in those remaining 13 states is one of HIAA's top priorities.

Summary and Conclusion

The flexibility of private insurance offers families and the elderly the preferred approach to prefunding long-term care for many Americans. And, over time, we believe private insurance will give millions of people an opportunity to be financially independent throughout their retirement years.

HIAA believes it would be a mistake to minimize the role of private insurance in designing a comprehensive national policy for long-term care. Instead, the public and private sectors must combine their efforts and knowledge to create a solution that will benefit most Americans today and in the future. This investment will pay off many times over as Americans grow older and it will avoid placing an insupportable tax burden on future generations.

In closing Mr. Chairman, HIAA will continue to work closely with the Robert Wood Johnson Foundation Program to Promote Long-Term Care Insurance for the Elderly. In addition, many of our members who sit on advisory panels across the eight participating states, will continue to lend their assistance and advice to the projects. We remain committed to this initiative and in support of S. 1998.

CICOA

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U.S. Senator Dan Coats
Member, U.S. Senate Subcommittee on Aging
Hearing on Long-Term Health Care
January 17, 1990
Indianapolis, Indiana

Your initiative to conduct this hearing on approaches and options for home health care is particularly timely following the repeal of the Medicare "Catastrophic" legislation and the forthcoming report of the Pepper Commission. CICOA and the nearly 200,000 older Hoosiers we serve appreciate the opportunity to participate in the deliberations on national policy for the future of long term care, and by implication, the nation's health policy.

Many of us believe the REAL catastrophe facing Hoosier elders and their families is the financial burden of long term care in a health care facility. With one in four over the age of 85 in a health-care facility, and this population expected to triple when the post-war "baby boom" generation matures, the nation MUST address the critical issue of paying for long term care.

The approach of the Pepper Commission seems to address the options, and has implications for national health policy as well:

- Enhancing existing systems such as Medicaid and establishing uniform standards.
- Employing some type of contributory system with insurances, tax credits, subsidies, and other cost-sharing mechanisms.
- Establishing a new social insurance program for all services, or one with a floor of coverage with gaps to be filled by private insurance.

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On issue is certain. The debate over "Catastrophic" clearly shows that the entire burden of payment cannot be put on the elderly, nor should we continue with the piece-meal system that is difficult to access and is increasingly unaffordable for all parties.

Another certainty is that Congress must remove the institutional bias in the current Medicaid system of long-term-care coverage and support family-focused efforts. Supporting family care-giving means a change in employment policies, perhaps tax credits to employers with approved family leave policies, in an effort to provide the best care to the growing numbers who will need it.

CICOA supports the call of HHS Secretary Sullivan to allow Medicaid coverage of community-based long-term-care services WITHOUT a special waiver, as a step that would immedicately remove the institutional bias. If Federal participation were now available to Indiana's home care program, the 27 million dollars of State funds would have leveraged a 74.4 million dollar home care program - an amount close to what it would cost for state-wide service.

In addition to supporting family care-giving efforts, home health and health care programs need to be age, disease, and income neutral at access, and buttressed with cost-sharing mechanisms that are realistic and equitable. I am including the position statement of the National Association of Area Agencies on Aging that expands on these issues.

Strong prevention and health promotion measures must be linked with health/home health care programs. These efforts in Indiana, such as such as the Healthy Older Hoosier program and the Wellness Centers efforts at Indianapolis senior centers, demonstrate the effectiveness of funds invested now to reduce costs later.

The asset protection and espousal prevention measures that survived the "Catastrophic" repeal may have removed incentives from a large share of the potential market for long-term-care insurance. To offer further protection may simply not be equitable. There still may be a role for long-term-care insurance and other "gap-filling" coverage in either a long-term-care program or a new system of national health care coverage. Such policies, of course, should have stringent consumer protection features - no prior hospitalization requirements for home care, for instance - and be accompanied by measures to stop abuses that have been documented in the sale of current "gap" policies.

In light of scarce resources requiring a best and highest use, the premiums that these policies generate might be invested in housing programs for seniors, including Home Equity Conversion mortgages, with accompanying investment credits and other incentives to do so.

Finally, there must be strong and effective quality control measures in home care programs. Allowing families great decision-making power over home care providers may be a solution. But effective training, monitoring, and reporting mechanisms are essential to quality care. Enforcement provisions must not be allowed to become captive of providers of care.

Thank you again for this opportunity to offer our opinions on this most important matter of home care for the elderly.

Presented by Duane Etienne, President, Central IN Council on Aging

Senator COATS. Well, again, I want to thank the audience for your participation and for your interest, thank our panelists for their presentation. It certainly was valuable for me, and I trust it was valuable for everyone here, to discuss the possibilities and the options and the concerns and the issues that are so important to this issue and to the elderly. We have a lot of tough policy decisions to make in the decade of the 1990's. They need to be made with the very best available information we have, and this certainly helps us obtain that information. All this will become part of the official Senate record, and we look forward to a continuing effort in addressing some very real questions. Thank you all very much for coming this morning.

[Whereupon, at 11:30 a.m., the subcommittee adjourned, subject to the call of the Chair.]

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